Contributions to Well-Being in Romantic Relationships

by

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TABLE OF CONTENTS

ABSTRACT

The present research examined the relationships among selected health-promoting behaviors as well as between these behaviors and life satisfaction, a proxy for overall quality of life. In past research, physical health, social support, self-disclosure, respect, and other relationship variables have been positively associated with life satisfaction, but depressive symptoms have been negatively associated with life satisfaction.

The six measures used for this study included the Satisfaction with Life Scale (Diener, Emmons, Larsen, & Griffen, 1985), the Relationship Assessment Scale (S. Hendrick, 1988), the Respect Toward Partner Scale (S. Hendrick & Hendrick, 2006), the Self-Disclosure Index (Miller, Berg, & Archer, 1983), the Multidimensional Scale of Perceived Social Support (Zimet, Dalhem, Zimet, & Farley, 1988), five items measuring exercise and six items measuring nutrition from the Health –Promoting Lifestyle Profile (Walker, Sechrist, & Pender, 1987), and the Center for Epidemiological Studies—Depressed Mood Scale (Radloff, 1977).

Correlations and regression analyses examined relationships among the variables. Significant correlations were found among the health-promoting variables, and between the health-promoting variables and life satisfaction for the total sample, the partnered sample, and the single sample. Health-promoting behaviors also predicted life satisfaction for each sample in regression equations. Respect toward partner, self-respect, self-disclosure, social support, physical activity, depressive symptoms, relationship satisfaction, commitment, and investment were predictors of life satisfaction for the total sample. Investment, depressive symptoms, respect toward partner, social support,

commitment, and relationship satisfaction were predictors for the partnered sample. Social support, physical activity, self-respect, and depressive symptoms were predictors of life satisfaction for the single sample. Compared to single individuals, partnered individuals reported greater life satisfaction and fewer depressive symptoms. However, single individuals were more physically active than partnered individuals. These findings are discussed in detail, and both clinical implications and future research possibilities are presented.

LIST OF TABLES

CHAPTER I

INTRODUCTION

Finding and maintaining romantic relationships are central tasks of life for most people. Relationships provide people with meaning and help define who they are. Many songs in American pop culture emphasize romantic relationships and the joy and support received from them. Taking a lesson from these songs and previous research concerning well-being and romantic relationships, the current research emphasizes the importance of behavior that is healthy, both emotionally and physically, so that people's relationships can be happier and their lives more satisfying.

Health-promoting behaviors have been investigated frequently and described in the empirical literature as aiding in the prevention of psychopathology and improving "quality of life." The term "health-promoting" includes behaviors that are directly related to positive well-being, such as maintaining good nutrition and engaging in frequent exercise. Past research has included the investigation of romantic relationships among health-promoting behaviors. However, though one or two of the constructs under consideration have been explored in conjunction with each other, most of the constructs have been explored independently of the other constructs. As Segrin (2005) stated, "the study of personal well-being encompasses physical health, mental health, social adjustment, and relationship satisfaction" (p. 547). Segrin (2005) also noted that all of these areas should be studied to advance our knowledge of well-being, and well-being is of central interest to the current research.

Physical Health-Promoting Behaviors

One of several questions that has surfaced in the literature concerns whether there is a link between physical and mental health and how that link relates to life satisfaction. Multiple studies have shown that men and women who are physically active perform more health-promoting behaviors and have greater life satisfaction (Ball, Crawford, & Kenardy, 2004; Dean, 1989; Hansson, Hilleras, & Forsell, 2005; S. Levy, 2003; Thome & Espelage, 2004). Good nutrition is also important to health-promotion (Ball et al., 2004). Research has also investigated the relationship between social support and health.

Social Support as a Health-Promoting Behavior

According to Cutrona (1996), within all definitions of social support there is the underlying assumption that in order to get basic needs met, people must be able to depend on each other. Social support networks, or "a set of people from whom an individual can reasonably expect to receive help in time of need" (Cunningham & Barbee, 2000, p. 275) developed through the process of evolution in order to help ensure human survival.

As stated by Cutrona (1996), "the primary benefit to the recipient of social support is protection against the deterioration of health and well-being that would otherwise be caused by the pressures of recent or ongoing stressful events" (p. 5). Social support has been found in some research to be the most important self-care and health-promoting behavior in maintaining well-being, even more than physical activity, engaging in pleasurable activities, and relaxation (Hansson, Hilleras, & Forcel, 2005).

One theorist stated that social support increases relationship satisfaction, because the social support a person receives from a partner helps to reduce emotional withdrawal and isolation from the partner (Cutrona, 1996). It is possible that social support may

increase the level of emotional intimacy in the relationship as well as maintain physical and mental health, because both partners are having good experiences (Cutrona). Further research emphasized the importance of a supportive spouse in helping the other partner maintain health behaviors such as nutrition and exercise, even when partners were of normal weight (Neumark-Sztainer et al., 1996; Piercy, 1996; Ptacek, Pierce, Dodge, & Ptacek, 1997). One way that social support can begin is by willingness for each partner to self-disclose to the other about his or her own personal experiences.

Self-Disclosure as a Health-Promoting Behavior

Self-disclosure has been defined as what individuals verbally relate to others about personal information such as the individual's private thoughts, feelings, and experiences (Derlega, Metts, Petronio, & Margulis, 1993). Previous research has demonstrated that self-disclosure promotes health in a variety of settings and groups of people, and that inhibition of disclosing traumatic, stressful events has an adverse effect on health. Pennebaker (1990) described the "holding back-opening up continuum" (p. 20) and stated that inhibiting emotional events is a physiological process and thus requires physical work to exert control over thoughts, feelings, and behaviors. Pennebaker (1990) argued that when people confront trauma psychologically and acknowledge their emotions, they are able to reduce the negative effects of inhibition both psychologically and physiologically so that they reduce their bodies' overall stress level. The work of Lutgendorf and Antoni (1999) extended Pennebaker's (1990) work by demonstrating that negative, intrusive thoughts decreased as people self-disclosed about traumatic events, which in turn improved their overall immune functioning.

Several studies have indicated that a lack of self-disclosure generally results in adverse effects. These adverse effects due to inhibition are also present specifically within the context of close relationships, since the effects relate to overall health. Byers (2005) found that poor communication, which includes lack of self-disclosure, is associated with decreases in both relationship satisfaction and sexual satisfaction. In contrast, people with good communication skills with their partners, including higher levels of self-disclosure, are more satisfied with their romantic relationship (Byers).

Relationship Satisfaction as a Health-Promoting Behavior

As previously mentioned, romantic partner support, self-disclosure and relationship satisfaction are each predictive of health-promoting behaviors (Piercy, 1996; Ptacek et al., 1997). Piercy (1996) showed that marital satisfaction is helpful to both men and women in practicing health-promoting behaviors. Relationship satisfaction also appears to be related to other constructs. Marital satisfaction is an important criterion for women in maintaining a healthy disposition, high life satisfaction, and positive relationship characteristics (Apt, Hurlbert, Pierce, & White, 1996). Relationship satisfaction has been shown to aid in maintaining well-being for men when their partners have been diagnosed with breast cancer (Segrin et al., 2006). Also, relationship satisfaction is particularly important in order for women to experience sexual satisfaction (Byers, 2001; Byers, 2005).

Other constructs to which relationship satisfaction is related include communication and sexual satisfaction. McCabe (1999) found that men and women in committed relationships place equal importance on communication, including reciprocity and quality of self-disclosure, as well as on the interpersonal aspects of a relationship, all

of which affect their relationship satisfaction (Baxter, 1979; S. Hendrick, 1981; S. Hendrick, 1988; Meeks, S. Hendrick, & Hendrick, 1998; Schumm, Barnes, Bollman, Jurich, & Bugaighis, 1986). Self-disclosure, like relationship satisfaction, is positively correlated with self-esteem, health-promoting behaviors, and self-care in a number of studies (S. Hendrick et al., 1998; Pennebaker, 1990; Pennebaker & Seagal, 1999; Pennebaker, Kiecolt-Glaser, & Glaser, 1988). Closely related to self-disclosure within the context of romantic relationships is the concept of respect, since reciprocal, affirming disclosure is in and of itself respectful.

Respect as a Health-Promoting Behavior

The idea of respect has long been emphasized in multiple cultures around the world as being of value (Hirsch, 2003). By definition in Latin cultures, *respeto* emphasizes the importance of harmony in interpersonal relationships and can be characterized by the avoidance of conflict in the interest of maintaining a quality relationship. Within psychology, the importance of specifically studying the concept of respect has just recently been emphasized in research on close relationships. Some of this research has been inspired by the writings of sociologist Sara Lawrence-Lightfoot (2000) who stressed the importance of respect and the six qualities that she considers characterize respect, including dialogue, attention, curiosity, healing, empowerment, and self-respect.

Although they acknowledged the work of Lawrence-Lightfoot (2000), Frei and Shaver (2002) employed a more clearly empirical approach to systematically explore respect and measure the construct in close relationships. Frei and Shaver (2002) found that respect was not seen as an emotion, but instead as an attitude directed toward a

person with whom a respondent was close. Frei and Shaver (2002) also found that there were 31 dimensions of the construct of respect that were consistent across ethnic groups, and their findings indicated that respect was very strongly positively correlated with relationship satisfaction.

S. Hendrick and Hendrick (2006) also examined the construct of respect, building conceptually directly on Lawrence-Lightfoot's (2000) work. Their intention was to develop a scale which measured respect toward a person's romantic partner and that could be used both clinically and in close relationship research. They developed the six-item Respect Toward Partner Scale. In their research, which focused the respondent's respect for their partner, the construct of respect toward romantic partner was correlated with relationship satisfaction and other relational variables, including self-disclosure and relationship commitment. S. Hendrick and Hendrick defined respect as an attitude composed of emotion, cognition, and behavior. As noted by scholars, research on respect is limited and needs to continue to be developed. The current research has several purposes, including further developing the concept of respect as it relates to other aspects of self-care. Before discussing this research, however, it is important to briefly consider the construct of well-being, which is an important global construct that ties together many aspects of the current research.

Well-Being

As noted in the beginning of the Introduction, well-being (in this study measured as life satisfaction) is extremely important and can be considered almost a proxy for general quality of life (e.g., Segrin, 2005). Diener (2000) stated that "subjective well-being in colloquial terms is sometimes labeled 'happiness'" (p. 34), or how satisfied a

person is with his or her life. According to Diener (2000), one facet of subjective well-being is satisfaction with specific areas of a person's life. As the focus of this paper is on romantic relationships, physical health, and emotional health, well-being is a natural construct to explore. Myers (2000) examined romantic relationships and how they relate to well-being. Based on Myers' (2000) findings, research demonstrates that most people are happier when they are in a romantic relationship than when they are not, provided the relationship is a happy one. People who are positive and happy tend to form happier relationships more easily and have more meaningful and physically healthy lives, because they are more attractive to others and are more positive (Myers, 2000; Taylor, Kemeny, Reed, Bower, & Gruenewald, 2000; Veenhoven, 1988).

Depressive Symptoms

As noted previously, strong social support, good physical health, successful romantic relationships, self-disclosure, respect for one's partner and for self, and other health promoting behaviors appear to be related to well-being. However, not engaging in health-promoting behaviors would appear to predict depressive symptoms. Previous research has indicated that individuals who are satisfied with their relationships are more likely to have health-promoting behaviors (Piercy, 1996; Ptacek et al., 1997). Therefore, it can be surmised that individuals who are unhappy in their relationships are unlikely to engage in health-promoting behaviors, which can result in psychopathology such as depressive symptoms. Relationship satisfaction is affected by psychopathology for both partners in a relationship. Depressive symptoms and anxiety both significantly negatively affect people's satisfaction with their own relationship, and a person's depressive symptoms negatively affect the person's partner's relationship satisfaction

(Fincham, Beach, Harold, & Osborne, 1997). Psychopathology such as depressive symptoms and anxiety may result from a lack of instituting self-care/health-promoting behaviors. Also, previous research has demonstrated that people generally tend to choose partners who are as psychologically unhealthy or psychologically healthy as they are (Whisman, Uebelacker, & Weinstock, 2004).

The Current Study

The current study investigated the relationships among a variety of health-promoting behaviors. Health-promoting behaviors include the domain of physical health, consisting of nutrition and exercise (Hannson et al. 2005; Walker, Sechrist, & Pender, 1987), and the domain of emotional health, consisting of social support, self-disclosure, respect, relationship satisfaction, and well-being (Cramer, 2006; Frei & Shaver, 2002; Walker et al., 1987). Additional constructs such as depressive symptoms were considered also. Each of these constructs has been explored only in concert with one or a few of the other constructs. Such exploration does not account for the possibility that if one construct has a relationship to another construct, and that construct has a relationship to yet another construct, then all three constructs most likely also have an association with each other. The current research considered such inter-relationships.

Therefore, the current research explored the associations between each of the health-promoting constructs mentioned previously and the associations between these constructs and overall well-being/life satisfaction, which is considered here as a proxy for quality of life.

Research Questions and Hypotheses

Research questions and the existing research on which they are built are discussed briefly below.

Research Question 1: How are physical health-promoting behaviors (exercise, nutrition) and emotional health-promoting behaviors (respect, self-disclosure, social support, relationship satisfaction, commitment, investment, lack of depressive symptoms, lack of alternative partners) related to each other?

Recent studies of physical health indicate that positive social support, particularly from a spouse, is predictive of a partner engaging in physical activity, which results in improved well being (Hays et al., 1993; Jones, 2002; Neumark-Sztainer et al., 1996). The empirical literature demonstrates that a person can benefit from social support that is provided when the person engages in self-disclosure (Wills 1985, 1990, as cited in Derlega et al., 1993). Pennebaker (1990) demonstrated that self-disclosure is beneficial for individuals, because the disclosure of emotions promotes positive emotional and physical health. Research indicates that self-disclosure in young couples is positively correlated with relationship satisfaction, and that when couples disengage from a romantic relationship, they engage in less self-disclosure (Baxter, 1979; S. Hendrick, 1981; S. Hendrick, 1988; Meeks, S. Hendrick, & Hendrick, 1998; Schumm, Barnes, Bollman, Jurich, & Bugaighis, 1986). Therefore, it is expected that self-disclosure will be positively correlated with relationship satisfaction.

Research Question 2: How are physical and emotional health-promoting behaviors (RQ 1) related to overall well-being, measured by life satisfaction? Research

by Diener (2000) and Myers (2000) shows links among positive emotional and physical behaviors and well-being.

Research Question 3: How do selected health-promoting behaviors predict well-being/ life satisfaction? Selected variables are expected to predict well-being, consistent with previous research (e.g., Myers, 2000).

Research Question 4: How do people in a current romantic relationship compare to people not in a current romantic relationship in terms of their health-promoting behaviors? Myers (2000) noted that people in happy marriages are more satisfied with life than separated or divorced persons.

CHAPTER II

METHOD

Participants

Participants (N = 314) were recruited from undergraduate students enrolled in Introductory Psychology courses or advanced undergraduate psychology courses at Texas Tech University. Students were given the opportunity to take the survey in an online or in vivo format. The distribution for the type of format was as follows: participants chose to participate in the study in vivo through a paper and pencil format (16.8%), and other participants chose to participate in the study through a website in the online format, which involved the same questions and answer choices (83.2%). An exploratory analysis was conducted to examine whether there was a difference in the two groups who participated by pencil and paper format or by internet format. A one-way ANOVA was conducted to determine whether there were significant differences. No significant differences were found between individuals who chose to take the survey in the paper and pencil format and those who chose to take the survey online (Appendix L).

The sample was 41% male and 59% female. The race/ethnicity demographics for the sample were as follows: Asian/ Pacific Islander (3.2%), Black/ African-American (5.4%), White, non-Hispanic (64.8%), Hispanic (14%), and reported other (12.7%). The age distribution of the sample was as follows: 19 or less (71.4%), 20 to 22 (25.1%), 23 to 30 (2.9%), 31-40 (.3%), and 40 or over (.3%). The relationship status distribution of the sample was as follows: not in a relationship (61.3%) and in a relationship (38.4%). Participants were asked how long they had been in their current relationship. The distribution for relationship length was: not in a relationship (61.3%) one month or less

(1.9%), one to three months (3.5%), three months to one year (10.5%), and over a year (22.9%). Participants were also asked if they had plans to get married or have a long-term relationship. The distribution for future relationship plans was as follows: no (1.6%), yes (87.3%), and not sure (10.2%).

Instruments

Several measures were used for this study. A 23-item *Background Inventory* (Appendix D) was used to assess sex, age, ethnicity, relationship status, and relevant love and relationship questions.

The *Satisfaction with Life Scale* (Appendix E) (SLS; Diener, Emmons, Larsen, & Griffen, 1985), a 5-item scale scored on a 5-point Likert basis, assesses the cognitive aspect of a person's subjective well-being. The Satisfaction with Life Scale loaded on one factor, and this factor accounted for 75% of the variance (Pavot, Diener, Colvin, & Sandvik, 1991). Psychometric properties for this measure were strong, with an internal consistency of .85 (Pavot & Diener, 1993) as well as test-retest reliability of .84, which was consistent at two-week and one-month time periods (Pavot et al., 1991). Cronbach's alpha for the current research was .79.

The *Relationship Assessment Scale* (Appendix F) (S. Hendrick, 1988) is a unifactorial measure of relationship satisfaction, which consists of 7 items in a 5-point Likert format. Previous research has shown that this scale has an alpha of .86 (S. Hendrick, 1988) and that it correlated highly with the Dyadic Adjustment Scale (Spainer, 1976). The alpha for the current research was .81. Additional items assessing commitment and investment were also included (Lund, 1985). Two items assessed the likelihood of finding an alternative partner. All these items were scored on a 5-point

Likert basis. Previous research on commitment has reported alphas of .87 and .89 (Hendrick, Hendrick, & Adler, 1988). Previous research on alternatives and investment has reported alphas of .78 for alternative partners (Hendrick & Hendrick, 1988) and .75 and .71 (Hendrick et al., 1988) for investment. Current alphas were: commitment (0.88), investment (0.78), and alternative partner (0.73).

The *Respect Toward Partner Scale* (Appendix G) (S. Hendrick & Hendrick, 2006) is a six-item scale designed to measure respect for one's romantic partner. The scale uses a 5-point Likert format ranging from 1 (strongly agree) to 5 (strongly disagree). Confirmatory factor analyses for the scale produced acceptable fit indices. The scale had a reported alpha reliability coefficient of .81. Construct validity for the respect measure was established through correlations with other relationship measures. The alpha for the current study was .87. A single additional item measured self-respect.

The *Self-Disclosure Index* (Appendix H) measures a person's tendency to self-disclose to another specific person (Miller, Berg, & Archer, 1983). This measure consists of 10 items in a 5-point Likert format. In this study, the specific person to whom the participant self-discloses was the romantic partner. This measure was administered in a format such that it asked for self-disclosure to the participant's romantic partner if the participant was in a romantic relationship, and to the person closest to him or her if he or she is not in a romantic relationship. Previous studies have shown that alpha coefficients are dependent on the person to whom the participant self-discloses, with alphas ranging from .86 to .93 (S. Hendrick, Hendrick, & Adler, 1988). The present study's alpha coefficient was .91 for a person's own self-disclosure toward his or her romantic partner.

The *Multidimensional Scale of Perceived Social Support* (Appendix I) measures a person's perception of the social support received from the person's friends, family, and romantic partner (Zimet, Dalhem, Zimet, & Farley, 1988). The 12-item scale consists of four items for each subscale, including perceived support from a person's friends, perceived support from a person's family, and perceived support from a person's romantic partner. The scale uses a 7-point Likert format but was used in a 5-point format for this study. High scores on each subscale indicate that the person perceives high social support from the people or person represented by that subscale, and low scores on subscales indicate that the person perceives little or no social support from the person or people represented by that subscale. The overall sum of the three subscales represents the respondent's overall satisfaction with the social support he or she has in life. Clara, Cox, Enns, Murray, and Torgrude (2003) reported Cronbach alphas for the Friends subscale of .94 for a psychiatric sample and .93 for a university sample. The authors also reported Cronbach alphas of .92 for both a psychiatric sample and for a university sample for the Family subscale, and Cronbach alphas of .94 for a psychiatric sample and .93 for a university sample for the Significant Other subscale. The reported Cronbach alphas for the total scale ranged from .85 to .88 (Clara et al., 2003). The Cronbach alpha for the present study was .92 for the Significant Other subscale, .87 for the Family subscale, and .89 for the Friends subscale. The Cronbach alpha for the total scale for the present study was .89.

Five items measured exercise as it relates to how often a person is practicing exercise as a health-promoting behavior (Appendix J) (Walker, Sechrist, & Pender, 1987). Items are arranged in a Likert-type format, ranging from 1 (never) to 4 (routinely).

These were strong items drawn from a longer measure of health promoting behaviors developed by Walker et al. (1987). These five items had a reported alpha of .81 in the Walker et al. study, and the current research had an alpha of .81.

Six items measured nutrition as it relates to how often a person is practicing nutrition as a health-promoting behavior (Appendix J) (Walker, Sechrist, & Pender, 1987). Items are arranged in a Likert-type format, ranging from 1 (never) to 4 (routinely). These were items drawn from a longer measure of health promoting behaviors developed by Walker et al. (1987). These six items had a reported alpha of .76 for the general population (adults ages 18 to 92) in the Walker et al. (1987) study, and an alpha of .78 for the present study.

Nezu, Nezu, McClure, and Zwick (2002) reported that in choosing an assessment instrument for depression the researcher's goals for the assessment, the researcher's target population to be assessed, the value of the instrument used, and the information source should all be considered. The authors recommended choosing an assessment that has already been used for the population under study in the researcher's research so that the measure can accurately assess that particular subgroup, as depression levels range from mild to severe (Nezu et al., 2002). The *Center for Epidemiological Studies—Depressed Mood Scale* (CES-D; Radloff, 1977) (Appendix K) is a 20-item scale used to measure the current level of depressive symptoms in the general population. The scale uses a 4-point Likert format ranging from 0 (rarely or none of the time) to 3 (most or all of the time) to indicate how often the person has experienced the depressive symptom within the past week. The scale has reported alpha reliability coefficients of .85 for the general population and .90 for psychiatric patient samples (Radloff, 1977 as cited in

Nezu, Nezu, McClure, & Zwick, 2002). The alpha for the current study was .75. The total scores on the CES-D range from 0 to 60. High scores on the scale indicate that a person is experiencing impairment. The total score is calculated using the sum of the scores on the questions, and a cutoff score of 16 is used to determine whether an individual is experiencing depression. A score of 16 or higher indicates that the person is reporting a significant number of depressive symptoms (Nezu et al., 2002).

Procedure

Undergraduates were recruited from their Introductory Psychology course (Psychology 1300) at Texas Tech University in Lubbock, Texas, and (for Psychology 1300) received course credit for participating in the study to fulfill a course requirement. Participants from the introductory course signed up for the study through the Texas Tech University Psychology Department's Experimetrix system, which is a computer program that enables students to sign up for research studies. Participants signing up in October 2006 of the Fall semester signed up to participate in an in vivo pen and paper study. Participants signing up for the experiment in November 2006 through the first week of December 2006 signed up for an online version of the study, in which questions were in the same format. Instructions were provided to students on the internet and in vivo to explain the study (Appendix C). All responses to the measures were kept confidential, and students who participated remained anonymous. The researcher and a research assistant had access to the information necessary for the administration of the measures and data analysis. Participants who chose to sign up for the in vivo version of the study were given a consent form, if necessary, prior to beginning the study, which explained participant confidentiality practices, and the consent forms were separated from the

confidentiality practices and questionnaires. The consent forms were kept in a locked file cabinet. Participants who chose to sign up for the online version of the study signed an online consent form which was kept in secure data files on the experimenter's website, separate from the data.

CHAPTER III

RESULTS

A variety of analyses were used to answer the research questions. The means and standard deviations for all variables for all participants are reported in Tables 1 and 2. An alpha level of .05 was used in all of the two-tailed significance tests. The correlation and regression analyses were performed separately for individuals who were in a relationship (partnered) and who were not in a relationship (single) as well as for the total sample, because of several differences in both means and correlations for partnered and single individuals. Simultaneous regression analyses were performed because of a lack of a priori information from the research literature regarding order of the predictor variables. T-tests were used to compare individuals in a relationship and those not in a relationship to assess the differences between groups on outcome variables selected from the correlational analyses. Finally, exploratory analyses were conducted to examine other areas of interest in the data that had not been determined a priori.

Correlation and Regression Analyses

Research Question 1: Relationships of health-promoting behaviors

How are physical health-promoting behaviors (exercise, nutrition) and emotional health-promoting behaviors (respect, self-disclosure, social support, relationship satisfaction, commitment, investment, lack of depression, lack of alternative partners) related to each other?

The correlational analyses for the associations between the variables of physical health (exercise, nutrition) and emotional health-promoting (respect, self-disclosure, social support, relationship satisfaction, commitment, investment, lack of depressive

symptoms, lack of alternative partners) for the total sample are presented in Table 3. The correlations for the same variables for partnered participants and single participants are presented in Table 4.

Table 1

Descriptive Statistics for the Total Sample

Scales	*M*	*SD*
Satisfaction with Life Scale	3.60	0.68
Respect Toward Partner Scale	1.66	0.69
Self-Respect item	1.38	0.71
Self-Disclosure Index	1.83	0.72
Multidimensional Scale of Perceived Social Support	1.72	0.61
Health Promoting Lifestyle Profile II--Physical Activity	2.36	0.63
Health Promoting Lifestyle Profile II—Nutrition	2.28	0.53
Center for Epidemiological Studies- Depressed Mood Scale	14.59	9.91
Relationship Assessment Scale	3.67	0.82
Commitment items	3.41	1.10
Alternative Partner items	3.58	1.00
Investment items	3.89	0.96

Note. $N = 314$.

Table 2

Descriptive Statistics for the Partnered and Single Samples

Scales	*M*	*SD*
Satisfaction with Life Scale	3.72	0.63
Respect Toward Partner Scale	1.35	0.50
Self-Respect item	1.29	0.58
Self-Disclosure Index	1.44	0.50
Multidimensional Scale of Perceived Social Support	1.49	0.42
Health Promoting Lifestyle Profile II--Physical Activity	2.38	0.66
Health Promoting Lifestyle Profile II—Nutrition	2.32	0.51
Center for Epidemiological Studies- Depressed Mood Scale	13.73	8.89
Relationship Assessment Scale	4.21	0.61
Commitment items	4.43	0.65
Alternative Partner items	3.36	1.22
Investment items	4.53	0.62
Satisfaction with Life Scale	3.52	0.70
Respect Toward Partner Scale	1.85	0.71
Self-Respect item	1.44	0.78
Self-Disclosure Index	2.07	0.73
Multidimensional Scale of Perceived Social Support	1.86	0.67
Health Promoting Lifestyle Profile II--Physical Activity	2.35	0.61
Health Promoting Lifestyle Profile II—Nutrition	2.26	0.55
Center for Epidemiological Studies- Depressed Mood Scale	15.18	10.50
Relationship Assessment Scale	3.33	0.75
Commitment items	2.77	0.81
Alternative Partner items	3.72	0.80
Investment items	3.49	0.91

Note. Means and standard deviations in the top portion of the chart are for the partnered sample, and means and standard deviations for the bottom portion of the chart are for the single sample. N = 121 for partnered sample and N = 193 for single sample.

Table 3

Correlations for the Total Sample

	1	2	3	4	5	6	7	8	9	10	11	12
1. Life Satisfaction	1											
2. Respect Toward Partner	**0.16**	1										
3. Self Respect	**0.18**	**0.39**	1									
4. Self Disclosure	**0.18**	**0.57**	**0.20**	1								
5. Social Support	**0.40**	**0.38**	**0.34**	**0.51**	1							
6. Physical Activity	**0.18**	0.10	0.06	0.10	0.15	1						
7. Nutrition	0.10	0.11	0.07	0.08	**0.19**	**0.47**	1					
8. Depressive Symptoms	**-0.39**	-0.11	**-0.19**	**-0.15**	**-0.22**	0.00	-0.09	1				
9. Relationship Satisfaction	**0.22**	**0.61**	0.14	**0.51**	**0.36**	**0.17**	0.11	-0.12	1			
10. Commitment	**0.19**	**0.54**	0.05	**0.57**	**0.39**	0.14	0.12	**-0.16**	**0.78**	1		
11. Alternative Partner	-0.08	-0.09	0.01	-0.05	-0.05	0.07	0.04	**0.15**	-0.13	**-0.20**	1	
12. Investment	**0.22**	**0.52**	0.08	**0.58**	**0.38**	0.14	**0.17**	-0.11	**0.64**	**0.72**	-0.45	1

Note. $p < .05$. Correlations in bold are significant two-tailed correlations. The complete names for the scales are as follows: 1. Life Satisfaction = Satisfaction with Life Scale, 2. Respect Toward Partner = Respect Toward Partner Scale, 3. Self-Respect = Self-Respect item, 4. Self-Disclosure = Self-Disclosure Index, 5. Social Support = Multidimensional Scale of Perceived Social Support, 6. Physical Activity = Physical Activity subscale of the Health-Promoting Lifestyle Profile-II, 7. Nutrition = Nutrition subscale of the Health-Promoting Lifestyle Profile-II, 8. Depressive Symptoms = Center for Epidemiological Studies—Depressed Mood Scale, 9. Relationship Satisfaction = Relationship Assessment Scale, 10. Commitment = Commitment items, 11. Alternative Partner = Alternative Partner items, 12. Investment = Investment items. $N = 314$ for total sample.

Table 4

Correlations for the Partnered and the Single Samples

	1	2	3	4	5	6	7	8	9	10	11	12
1. Life Satisfaction	**1**	0.07	**0.25**	0.11	**0.42**	**0.19**	0.10	**-0.36**	0.06	0.03	0.01	0.10
2. Respect Toward Partner	**0.24**	**1**	**0.37**	**0.52**	**0.30**	0.14	-0.00	-0.04	**0.52**	**0.46**	0.06	**0.45**
3. Self Respect	0.00	**0.40**	**1**	0.17	**0.39**	0.04	0.01	**-0.20**	0.11	-0.03	0.06	0.04
4. Self Disclosure	0.19	**0.43**	0.17	**1**	**0.41**	0.14	0.05	-0.05	**0.39**	**0.43**	0.16	**0.51**
5. Social Support	**0.27**	**0.36**	0.11	**0.42**	**1**	0.18	**0.21**	-0.17	**0.24**	**0.25**	0.07	**0.27**
6. Physical Activity	0.14	0.22	0.09	0.02	0.09	**1**	**0.43**	0.04	**0.23**	**0.23**	0.15	**0.20**
7. Nutrition	0.09	**0.32**	0.20	0.09	0.12	**0.53**	**1**	-0.07	0.07	0.15	0.12	**0.21**
8. Depressive Symptoms	**-0.41**	-0.15	-0.14	**-0.28**	**-0.29**	-0.06	-0.11	**1**	-0.00	-0.04	0.07	-0.02
9. Relationship Satisfaction	**0.40**	**0.57**	0.05	**0.33**	**0.29**	0.13	0.14	-0.20	**1**	**0.67**	0.14	**0.53**
10. Commitment	**0.33**	**0.34**	0.07	**0.36**	**0.29**	0.08	0.04	**-0.24**	**0.71**	**1**	0.03	**0.60**
11. Alternative Partner	-0.13	-0.16	0.02	-0.15	-0.13	-0.00	-0.03	**0.24**	**-0.29**	**-0.28**	**1**	0.11
12. Investment	**0.36**	**0.29**	0.02	**0.32**	**0.29**	0.05	0.07	-0.16	**0.46**	**0.53**	-0.01	**1**

Note. $p < .05$. Correlations for partnered persons are below the diagonal, and correlations for single persons are above the diagonal. Correlations in bold are significant two-tailed correlations. The complete names for the scales are as follows: 1. Life Satisfaction = Satisfaction with Life Scale, 2. Respect Toward Partner = Respect Toward Partner Scale, 3. Self-Respect = Self-Respect item, 4. Self-Disclosure = Self-Disclosure Index, 5. Social Support = Multidimensional Scale of Perceived Social Support, 6. Physical Activity = Physical Activity subscale of the Health-Promoting Lifestyle Profile-II, 7. Nutrition = Nutrition subscale of the Health-Promoting Lifestyle Profile-II, 8. Depressive Symptoms = Center for Epidemiological Studies—Depressed Mood Scale, 9. Relationship Satisfaction = Relationship Assessment Scale, 10. Commitment = Commitment items, 11. Alternative Partner = Alternative Partner items, 12. Investment = Investment items. $N = 121$ for partnered sample and $N = 193$ for single sample.

A number of significant positive correlations were found for the total sample. Respect toward partner was related to self-respect, self-disclosure, social support, relationship satisfaction, commitment, and investment. Self-respect was related to self-disclosure and social support. Self-disclosure was related to social support, relationship satisfaction, commitment, and investment. The positive correlation between self-disclosure and relationship satisfaction was consistent with what had been expected (see Research Question One in Introduction). Social support was related to nutrition, relationship satisfaction, commitment, and investment. Physical activity was related positively to nutrition and relationship satisfaction. Nutrition was related positively to investment. Depressive symptoms and alternative partner were related positively, as were relationship satisfaction and commitment, relationship satisfaction and investment, and commitment and investment. The following significant negative correlations were found for the total sample: depressive symptoms and self-respect, depressive symptoms and self-disclosure, depressive symptoms and social support, depressive symptoms and commitment, and alternative partner and commitment.

Research from previous studies has shown that individuals may be more likely to engage in health-promoting behaviors if they are in a happy relationship. Consistent with previous research, the following positive correlations were found for individuals in a relationship: respect for partner and self-respect, self-disclosure, social support, nutrition, relationship satisfaction, commitment, and investment. Self-disclosure was related to social support, relationship satisfaction, commitment, and investment. Social support was related to relationship satisfaction, commitment, and investment. Also positively related were physical activity with nutrition, depressive symptoms with alternative

partner, relationship satisfaction with commitment and investment, and commitment with investment. The following negative correlations were found for the relationship sample: self-disclosure and depressive symptoms, social support and depressive symptoms, commitment and depressive symptoms, alternative partner and relationship satisfaction, and alternative partner and commitment.

For the single individuals not in a relationship, the following significant positive correlations were found: respect toward partner and self-respect, self-disclosure, social support, relationship satisfaction, commitment, and investment. Self-respect and social support were related. Self-disclosure was related to social support, relationship satisfaction, commitment, and investment. Social support was related to nutrition, relationship satisfaction, commitment, and investment. Physical activity was related to nutrition, relationship satisfaction, commitment, and investment. Nutrition and investment were related, as were relationship satisfaction with commitment and investment, and commitment with investment. Depressive symptoms and self-respect were negatively correlated for the single sample.

Research Question 2: Health-Promoting Behaviors and Well-Being

How are physical and emotional health-promoting behaviors (RQ1) related to overall well-being, measured by life satisfaction?

The analytic approach used for Research Question 1 was also used for Research Question 2. Correlations for the total sample are presented in Table 3 and those for partnered and single individuals are presented in Table 4.

For the total sample, life satisfaction was positively correlated with respect for partner, self-respect, self-disclosure, social support, physical activity, relationship

satisfaction, commitment, and investment, which was consistent with previous research. Depressive symptoms and life satisfaction were negatively correlated for the total sample, as expected.

For the relationship sample, life satisfaction was positively related to respect toward partner, social support, relationship satisfaction, commitment, and investment. The correlation between life satisfaction and depressive symptoms was negative and significant. For the single sample, life satisfaction was positively related to self-respect, social support, and physical activity. Depressive symptoms and life satisfaction were negatively correlated for the single sample.

The individuals who were partnered differed from the individuals who were single on 10 of the 66 correlation pairs shown in Table 4 (including correlations both above and below the diagonal). In all 10 significantly different correlation pairs, only one of the two correlations was statistically significant. Thus it could be argued that these significant differences, while statistically significant, are not clinically significant. However, four of the ten significantly different correlations occurred for well-being and four other variables, indicating a possible pattern. Thus these four significantly different correlations will be mentioned briefly. Life satisfaction and self-respect were positively correlated for single persons ($r = 0.25$, $p < .05$), but not for partnered persons (r = 0.00, *NS*). These correlations differed at the .05 level by z-test ($z = 2.17$, $p < .05$) (Bruning & Kintz, 1977). Life satisfaction was correlated positively and significantly with relationship satisfaction, commitment, and investment ($r = 0.40$, $r = 0.33$, $r = 0.36$, all at $p < .05$) for the partnered sample, but though positively correlated for the single adult sample, life satisfaction was not significantly correlated with relationship satisfaction,

commitment, and investment for single persons ($r = 0.06$, $r = 0.03$, $r = 0.10$, all *NS)*. These correlations differed at the .05 level by z-test ($z = 3.10$ for relationship satisfaction, $z = 2.66$ for commitment, $z = 2.36$ for investment, all at $p < .05$). Because single adults were asked to think about previous relationships and partnered adults were asked to think about their current relationship, it was expected by the author that single adults would find relationship satisfaction, commitment, and investment to be less relevant to their overall well-being (satisfaction with life) than would partnered persons reporting about current relationships.

Research Question 3: Health-Promoting Behaviors Predict Well-Being

How do selected health-promoting behaviors predict well-being/ life satisfaction?

The variables were selected for simultaneous regressions based on significant correlations for the total sample, for partnered individuals, and for single individuals.

For the total sample, respect toward partner, self-respect, self-disclosure, social support, physical activity, depressive symptoms, relationship satisfaction, commitment, and investment were the predictor variables, and life satisfaction, which was considered to be a measure of well-being, was the dependent variable for the simultaneous regression analysis. The results are shown in Table 5. For the total sample, the $R^2 = 0.29$, the adjusted $R^2 = 0.27$, and the overall $F = 13.53$ ($p < .05$). These predictors accounted for 27% of the variance. However, social support (standardized $\beta = 0.32$, $\underline{p} < .01$), physical activity (standardized $\beta = 0.12$, $p < .01$), and depressive symptoms (standardized $\beta = -0.32$, $p < .01$) were the only significant predictors for the total sample.

Table 5

Summary of Regression for Variables Predicting Well-Being for the Total Sample

Variable	*B*	*SE B*	*β*
Respect Toward Partner	0.04	0.07	0.04
Self Respect	0.02	0.05	0.02
Self-Disclosure	0.09	0.07	0.10
Social Support	**0.36**	0.07	**0.32**
Physical Activity	**0.13**	0.05	**0.12**
Depressive Symptoms	**-0.02**	0.00	**-0.32**
Relationship Satisfaction	0.10	0.07	0.12
Commitment	-0.06	0.06	-0.10
Investment	0.08	0.05	0.11

Note. Respect Toward Partner = Respect Toward Partner Scale, Self-Respect = Self-Respect item, Self-Disclosure = Self-Disclosure Index, Social Support = Multidimensional Scale of Perceived Social Support, Physical Activity = Physical Activity Subscale of the Health-Promoting Lifestyle Profile II, Depressive Symptoms = Epidemiological Studies—Depressed Mood Scale, Relationship Satisfaction = Relationship Assessment Scale, Commitment = Commitment items, and Investment = Investment items. Values in bold are significant at $p < .05$. $N = 314$.

Table 6

Summary of Regression for Variables Predicting Well-Being for the Partnered Sample

Variable	*B*	*SE B*	*β*
Respect Toward Partner	0.03	0.13	0.03
Social Support	0.10	0.13	0.06
Depressive Symptoms	**-0.02**	0.01	**-0.32**
Relationship Satisfaction	**0.30**	0.13	**0.29**
Commitment	0.07	0.12	0.08
Investment	**0.20**	0.20	**0.09**

Note. Respect Toward Partner = Respect Toward Partner Scale, Social Support = Social Support Multidimensional Scale of Perceived Social Support, Depressive Symptoms = Center for Epidemiological Studies—Depressed Mood Scale, Relationship Satisfaction = Relationship Assessment Scale, Commitment = Commitment items, Investment = Investment items. Values in bold are significant at $p < .05$. $N = 121$.

Table 7

Summary of Regression for Variables Predicting Well-Being for the Single Sample

Variable	*B*	*SE B*	*β*
Self-Respect	0.01	0.05	0.01
Social Support	**0.34**	**0.06**	**0.31**
Physical Activity	**0.14**	0.53	**0.13**
Depressive Symptoms	**-0.02**	0.00	**-0.32**

Note. Self-Respect = Self Respect Scale, Social Support = Social Support Total Scale from the Multidimensional Scale of Perceived Social Support, Physical Activity = the Physical Activity Subscale from the Health-Promoting Lifestyle Profile II, and Depressive Symptoms= the total score from the Center for Epidemiological Studies—Depressed Mood Scale. Values in bold are significant at $p < .05$. $N = 193$.

Respect toward partner, social support, depressive symptoms, relationship satisfaction, commitment, and investment were the predictor variables for life satisfaction for the partnered sample, and life satisfaction was used as the dependent variable for the simultaneous regression analysis. The results are shown in Table 6. For the partnered sample, the $R^2 = 0.27$, the adjusted $R^2 = 0.25$, and the overall $F = 18.63$ ($p < .05$). These predictors accounted for 25% of the variance. However, depressive symptoms (standardized $\beta = -0.32$, $p < .05$) and social support (standardized $\beta = 0.32$) were the only significant predictors for the partnered sample.

Self-respect, social support, physical activity, and depressive symptoms were the predictor variables for life satisfaction for the single sample, and life satisfaction was used as the dependent variable for the simultaneous regression analysis. The results are shown in Table 7. For the single sample, the $R^2 = 0.27$, the adjusted $R^2 = 0.26$, and the overall $F = 28.74$ ($p < .05$). These predictors accounted for 26% of the variance. However, social support (standardized $\beta = 0.31$, $p < .05$), physical activity (standardized $\beta = 0.13$, $p < .01$), and depressive symptoms (standardized $\beta = -0.32$, $p < .05$) were the only significant predictors for the single sample.

Research Question 4: Relationship Status and Health-Promoting Behaviors

How do people in a current romantic relationship compare to people not in a current romantic relationship in terms of their health promoting behaviors?

Mean differences of the variables for two groups, partnered individuals and single individuals, were assessed on the following variables of interest: respect toward partner, self-respect, self-disclosure, social support, physical activity, nutrition, depressive symptoms, relationship satisfaction, commitment, alternative partner, and investment. A

two-tailed, independent samples t-test was performed for each outcome variable to examine whether there was a significant difference between the two groups. Although no formal hypotheses were proposed, the groups were expected to differ on some variables, based on previous research and theorizing that being "connected" to others is good for people.

There was a significant difference between partnered individuals and single individuals for life satisfaction, with partnered individuals reporting greater life satisfaction, t (312) = -2.61, $p < .05$. A significant difference was found also for respect for partner, with partnered persons reporting a greater respect for their partners than single persons, t (312) = 6.84, $p < .05$. Individuals who were partnered engaged in significantly more self-disclosure than those who were single, t (312) = 8.45, $p < .05$. However, single individuals reported significantly more social support than partnered individuals, t (312) = 5.47, $p < .05$. No significant differences were found between groups for physical activity or nutrition, which was not supportive of the author's expectation that individuals in relationships would engage in physical activity and health-promoting behaviors more than would individuals not in a relationship. Individuals in a relationship reported greater relationship satisfaction, t (312) = -10.90, $p < .05$, greater commitment to their partners, t (312) = -19.06, $p < .05$, and greater investment in their relationship, t (312) = -10.97, $p < .05$ than those not in a relationship. In contrast, individuals not in a relationship reported a greater number of alternative partners, t (312) = 3.18, $p < .05$, than those not in a relationship. No significant differences were found between partnered and single individuals for depressive symptoms. Overall, the groups differed understandably on variables related to a partner, with partnered individuals

reporting more respect for partner as well as more satisfaction, commitment, investment, and self-disclosure. Single individuals reported more social support, but less life satisfaction.

Exploratory Analyses

Gender by Group Comparisons

Several exploratory analyses were also conducted. Gender differences and group (in a relationship, not in a relationship) differences for life satisfaction were assessed by a two-way ANOVA. Means and standard deviations for relationship status and gender are found in Table 8. The two-way ANOVA table for gender differences and group differences for life satisfaction are found in Table 9. A significant difference was found for relationship status for life satisfaction, $F\ (1, 313) = 6.48$, $p < .05$, with individuals in a relationship having more life satisfaction than those not in a relationship, consistent with t-test results reported previously. No significant differences for life satisfaction were found for gender, $F\ (1, 313) = 0.70$, $p < .05$, or for the relationship by gender interaction, $F\ (1, 313) = 0.09$, $p < .05$).

Social Support

Finally, an exploratory analysis was conducted to determine whether different types of social support were correlated with the other variables. Previously, total social support scores were used for analyses. In the exploratory analysis, social support from a person's family, social support from a person's significant other, and social support from a person's friends were examined individually. Correlations for the total sample as well as the partnered and single samples are presented in Table 10.

Table 8

Descriptive Statistics for Gender and Relationship Status

Gender	Relationship Status	Mean	S.D.	N
Male	Not in a Relationship	3.57	0.73	86
Male	In a Relationship	3.75	0.61	43
Female	Not in a Relationship	3.48	0.67	107
Female	In a Relationship	3.71	0.64	78

Note. $N = 86$ for single males, $N = 43$ for partnered males, $N = 107$ for single females, $N = 78$ for partnered females.

Table 9

Analysis of Variance for Life Satisfaction

Source	*SS*	*df*	*MS*	*F*	*Sig.*
Relationship Status	2.95	1	2.95	6.48	0.01
Gender	0.32	1	0.32	0.70	0.40
Relationship Status x Gender	0.04	1	0.04	0.09	0.77
Error	140.97	310	0.46		
Total	4203.88	314			

Note. $p < .05$. $N = 185$ females, $N = 129$ males, $N = 193$ singles, $N = 121$ partnered.

Social Support-Significant Other

Previous research has shown evidence that social support from a significant other may be related to a person's health promoting behaviors. Therefore, social support-significant other was correlated with all other variables. Social support-significant other was found to be positively correlated with life satisfaction, respect toward partner, self-disclosure, relationship satisfaction, commitment, and investment for both the single and partnered samples.

All of the following correlations were significant for both partnered and single samples: social support-significant other and life satisfaction, respect toward partner, self-disclosure, relationship satisfaction, commitment, and investment. For the single sample only, social support-significant other was significantly and positively correlated with self-respect and physical activity. For the partnered sample only, social support-significant other was negatively and significantly correlated with depression and alternative partner. For the total sample, social support-significant other was significantly, positively correlated with life satisfaction, respect toward partner, self-respect, self-disclosure, physical activity, relationship satisfaction, commitment, and investment. It was significantly and negatively correlated with depression.

Social Support-Family

Social support-family was also examined. For the single sample only, social support-family was positively and significantly correlated with life satisfaction, respect toward partner, self-respect, self-disclosure, and nutrition. Social support-family was correlated only with respect toward partner for partnered adults. Social support-family was correlated positively and significantly with life satisfaction, respect toward partner,

self-respect, self-disclosure, physical activity, relationship satisfaction, commitment, and investment for the total sample.

Social Support-Friends

Social support-friends was also analyzed with other variables. For the single adult sample, positive and significant correlations were found for social support-friends and life satisfaction, respect toward partner, self-respect, self-disclosure, and investment. A negative correlation was found with depression. For the partnered sample, only one significant positive correlation was found between social support-friends and self-disclosure. For the total sample, social support-friends was positively and significantly correlated with the following variables: life satisfaction, respect toward partner, self-respect, self-disclosure, relationship satisfaction, commitment, and investment. It was negatively and significantly correlated with depression.

Correlations Among Social Support Scales

Correlational analyses were also conducted to examine the relationship among the three social support sub-scales (see Table 11). All of the sub-scales were positively and significantly correlated with the Social Support-Total measure, so only the correlations among the significant other, family, and friends scales will be discussed. Social support-signficant other was significantly and positively correlated with social support-family for the partnered and total samples, and with social support-friends for the single, partnered, and total samples. Social support-family was positively and significantly correlated with social support-friends for the single and total samples.

Table 10

Correlations for the Single, Partnered, and Total Samples

Variables	1	2	3	4	5	6	7	8	9	10	11
Single Sample											
Social Support- Significant Other	**0.30**	**0.22**	**0.24**	**0.41**	**0.19**	0.13	-0.11	**0.31**	**0.37**	0.06	**0.27**
Social Support- Family	**0.38**	**0.22**	**0.34**	**0.23**	0.12	**0.22**	-0.08	0.07	0.05	0.05	0.14
Social Support- Friends	**0.34**	**0.28**	**0.36**	**0.45**	0.11	0.14	-0.22	0.17	0.15	0.06	**0.22**
Partnered Sample											
Social Support- Significant Other	**0.31**	**0.41**	-0.05	**0.48**	0.09	0.11	**-0.33**	**0.41**	**0.44**	**-0.26**	**0.41**
Social Support- Family	0.14	**0.24**	0.19	0.12	0.02	0.13	-0.15	0.12	0.12	-0.04	0.14
Social Support- Friends	-0.17	0.15	0.01	**0.39**	0.09	0.01	-0.19	0.16	0.13	0.02	0.14
Total Sample											
Social Support- Significant Other	**0.32**	**0.36**	**0.21**	**0.52**	**0.15**	0.14	**-0.18**	**0.47**	**0.53**	-0.10	**0.44**
Social Support- Family	**0.31**	**0.25**	**0.31**	**0.23**	0.08	**0.20**	-0.12	**0.13**	**0.14**	-0.01	**0.18**
Social Support- Friends	**0.30**	**0.27**	**0.27**	**0.44**	0.10	0.11	**-0.23**	**0.21**	**0.20**	-0.00	**0.24**

Note. $p < .05$. Significant correlations are displayed in bold. Correlations at the top of the table show the values for the single sample, correlations in the middle section of the table show the partnered sample values, and correlations in the bottom section of the table show the correlations for the total sample. Numbers across the top represent the following variables: 1 = Satisfaction with Life Scale; 2 = Respect Toward Partner Scale; 3 = Self-Respect Scale; 4 = Self-Disclosure Index; 5 = Physical Activity subscale of the Health-Promoting Lifestyle Profile II; 6 = Nutrition subscale of the Health-Promoting Lifestyle Profile II; 7 = Center for Epidemiological Studies- Depressed Mood Scale; 8 = Relationship Assessment Scale; 9 = Commitment items; 10 = Alternative Partner items; 11 = Investment items. $N = 193$ for single sample, 121 for partnered sample, and 314 for total sample.

Table 11

Social Support Correlations for the Single, Partnered, and Total Samples

Variables	1	2	3	4
Single Sample				
1. Social Support-Significant Other	**1**			
2. Social Support-Family	**0.35**	**1**		
3. Social Support-Friends	**0.54**	**0.45**	**1**	
4. Social Support-Total	**0.82**	**0.75**	**0.82**	**1**
Partnered Sample				
1. Social Support-Significant Other	**1**			
2. Social Support-Family	0.12	**1**		
3. Social Support-Friends	**0.38**	0.20	**1**	
4. Social Support-Total	**0.60**	**0.74**	**0.73**	**1**
Total Sample				
1. Social Support-Significant Other	**1**			
2. Social Support-Family	**0.31**	**1**		
3. Social Support-Friends	**0.51**	**0.38**	**1**	
4. Social Support-Total	**0.80**	**0.73**	**0.79**	**1**

Note. $p < .05$. Correlations in bold type are significant. The following variables are sub-scales: 1 = Social Support-Significant Other Sub-scale from the Multidimensional Perceived Social Support Scale, 2 = Social Support-Family Sub-scale from the Multidimensional Perceived Social Support Scale, 3 = Social Support- Friends Sub-scale from the Multidimensional Perceived Social Support Scale. Variable 4 = Social Support-Total is the total score for all three subscales of the Multidimensional Perceived Social Support Scale. The top portion of the table represents the single sample, the middle portion of the table represents the partnered sample, and the bottom portion of the table represents the total sample. $N = 193$ for single sample, 121 for partnered sample, and 314 for the total sample.

CHAPTER IV

DISCUSSION

Because of the many and varied findings of this research, major findings and themes are discussed in the context of previous research and also are discussed as they relate to the expected outcomes for the current work.

The Respect Variables

Respect is characterized by many positive qualities, including being able to participate in genuine communication, being fully engaged, having true interest in the thoughts, feelings, and fears of other people, helping others to feel worthy through nurturing, aiding others in being independent in their decision-making through helping them to believe in themselves and their abilities, and believing in one's own positive qualities (Lawrence-Lightfoot, 2000). These aspects of respect would seem to relate to satisfactory personal relationships and contribute to overall well-being. More recently, researchers have focused on respect within the context of close relationships. S. Hendrick and Hendrick (2006) stated in their research that respect involved two people being in mutual standing in the relationship and feeling that the relationship was a place of support and trust so that both people could feel comfortable disclosing their private confidences.

S. Hendrick and Hendrick (2006) studied three components of respect in close relationships through their scale, which measured respect toward partner, perceived partner respect, and self-respect. The Hendricks found that respect correlated with relationship satisfaction, relationship commitment, and other relationship variables, as

well as self-disclosure. As noted in the current results section, correlations between life satisfaction (a proxy variable for well-being) and two of the different kinds of respect (respect toward partner and self-respect) were examined. Both respect toward partner and self-respect were positively and significantly correlated with life satisfaction for the total sample, so both were included as predictors for life satisfaction in the total sample. But they were not significant predictors.

Respect toward partner and self-respect were significantly and differentially correlated with life satisfaction for the partnered and single samples. Only respect toward partner was correlated with life satisfaction for the partnered sample, but it was not a significant predictor of satisfaction. Interestingly enough, self-respect was not significantly correlated with life satisfaction, and so was not included as a predictor for life satisfaction.

For the single adult sample, only self-respect was used as a predictor for life satisfaction, as it was positively and significantly correlated with life satisfaction. Self-respect was not a significant predictor for life satisfaction, however. Self-respect was related to life satisfaction, most likely because single adults have more time to engage in self-care practices than partnered adults, who spend more time focusing on the other person in a relationship. Respect toward partner was most likely related to life satisfaction for partnered adults for precisely the same reason.

Self-Disclosure

Previous researchers have found that self-disclosure is important in strengthening romantic relationships through increasing commitment, and that self-disclosure is important for all people to aid in relieving physical symptoms and emotional traumas

(McKenna, Green, & Gleason, 2002; Pennebaker & Chung, 2007; Slatcher & Pennebaker, 2006). Veenhoven (1988) indicated that individuals who are more cheerful and friendly have greater social support networks than those that are not, and research also indicates that individuals who are depressed have fewer social networks to release traumas. It is common knowledge that depressed individuals are more dissatisfied with their lives than people who are not depressed, so therefore it would be expected that fewer friendships would lead to less self-disclosure because of a lack of available individuals with whom to relieve stressors either verbally or nonverbally. As with the respect variables, self-disclosure was examined in the total, single, and partnered samples for positive, significant correlations so that it could be included as a predictor for life satisfaction for all three models.

Self-disclosure was significantly and positively correlated with life satisfaction for the total sample only, and not the partnered or single samples. It is not surprising that self-disclosure was not positively and significantly correlated with life satisfaction for single adults, because single adults were asked to rate their self-disclosure toward a past love partner. Baxter (1979) found that adults engage in less self-disclosure with a romantic partner when they disengage from their significant other. Therefore, the single adults in the sample have disengaged from their previous partners, which would likely result in perceptions that they disclosed less to a partner in the past. As for partnered adults, self-disclosure was most likely not significantly and positively correlated with well-being because most of the college sample is still in the stage of experimenting with dating and new relationships. It is likely that most people are still in the early phases of developing trust and deciding what is appropriate to share with a partner. However, we

do know that adults in both samples see self-disclosure in relationships to be important, which is consistent with previous research by McCabe (1999) indicating that men and women in committed relationships place equal importance on communication in relationships.

Interestingly, the author's study has shown the partnered individuals engage in more self-disclosure than single individuals, although single individuals have a greater social support network. It seems that partnered individuals rely more on their partners for social support and self-disclosure, and single individuals rely on a greater network of friends and family for social support and self-disclosure. However, partnered individuals reported greater life satisfaction than single individuals.

Social Support

As noted previously, individuals receive social support from a variety of networks, including their significant others, family, and friends (Gottleib, 1985). Cutrona (1996) reported that the main benefit of receiving social support is to protect the person receiving social support from stressors, and help the person maintain well-being or life satisfaction. Other research has indicated that social support is the greatest predictor of maintaining well-being (Hansson, Hilleras, & Forcel, 2005). Therefore, social support was examined for its relationship to life satisfaction. Social support was positively correlated with life satisfaction for the total, partnered, and single samples, and was therefore included in all three models to predict life satisfaction. Social support was a significant predictor for only the total and single samples, but did account for some of the variance for the partnered sample, despite not being a significant predictor. Social support, which collectively includes social support from family, friends, and significant

others, was not a significant predictor for the partnered sample, because further analyses showed that social support from a significant other was the only subscale that was positively and significantly correlated with life satisfaction for partnered individuals.

For the total sample and single sample, total social support was significantly correlated to life satisfaction and was a significant predictor of life satisfaction in the regression analyses. And all three subscales of the social support measure were related to satisfaction for the total and single samples. Therefore, it appears that partnered individuals see their partners as the greatest source of social support in relation to satisfaction, while single adults' life satisfaction is related to a broader base of social support. This is consistent with previous research which has indicated that spousal support is more important than friendship for partnered individuals in maintaining physical health and wellness, and a lack of social support from a spouse cannot be compensated for by support from family and friends (Coyne & Anderson, 1999; Coyne & DeLongis, 1986; Piercy, 1996; Pistrang & Barker, 1995; Ptacek et al., 1997).

The Physical Health Variables

The work of multiple authors has been reviewed recently by Taylor, Kemeny, Reed, Bower, and Gruenewald (2000), who found across a number of studies that emotional health is linked to physical health. Positive emotional coping skills can lead to greater resilience in life, and greater well-being, greater subjective health, and greater emotional health (Frankl, 1963; N. Levy, 2003; O'Leary & Ickovics, 1995; Schaefer & Moos, 1992). Physical exercise, nutrition, and physical health are positively related to positive well-being, and are helpful in aiding individuals in decision-making and in using positive coping skills in problem-solving situations (Hansson, Hilleras, & Forsell, 2005;

Ingeldew & McDonaugh, 1998). Therefore, the author expected positive and significant correlations between nutrition and life satisfaction, and physical activity and life satisfaction for the total, partnered, and single samples. Life satisfaction was significantly positively correlated only with physical activity for the total and single samples, however. Life satisfaction was not significantly correlated with physical activity for the partnered sample, and nutrition was not significantly correlated with life satisfaction for any of the three samples. Therefore, physical health was used as a predictor of well-being for only the total and single sample models for life satisfaction. Physical health was a significant predictor for well-being for both the total and single samples, which was consistent with the research indicating that physical health is related to well-being.

However, physical health was neither related to nor predictive of life satisfaction for partnered adults probably because of the population under study. It is highly probable that individuals in college who are partnered are more focused on their partners, and have less time available for self-care practices such as physical activity, as compared to those who are single. Most of the partnered individuals in the sample were in relatively new relationships, and so those individuals are probably still in the process of learning how to be a partner and learning to find individual interests outside the relationship. Nutrition is most likely not a significant predictor of life satisfaction for college students, because college is a time when most students engage in unhealthy eating practices and "gain the freshman fifteen." Nutrition is most likely more important to partnered individuals later in life who have to focus on nutrition because of a greater risk of health concerns.

Depressive Symptoms

One health concern of particular note in college is the number of individuals leaving home for the first time who experience depression. Depressive symptoms were expected to be strongly negatively correlated with well-being for all three samples. Going to college for the first time is often scary to many in the freshman population and can cause individuals to develop depressive symptoms, because of the lack of support networks they have when coming to a new environment. As suggested by a number of studies, social support is important for helping individuals to meet their interpersonal needs and is necessary for survival during times of adversity (Cunningham & Barbee, 2000; Cutrona, 1996). Coker, Smith, Thompson, McKeown, Bethea, and Davis (2002) reviewed numerous studies which concluded that individuals who have social support are protected from developing depression when they face difficult times. Therefore, social support is generally assessed when an individual who is a college student presents with depression at college counseling centers. Other individuals besides college students have also had difficulties with depression.

Seal (1996) has indicated that psychiatric patients suffering from depression have lower levels of life satisfaction and fewer self-care strategies. The work of Nezu et al. (2002) has stressed the importance of choosing the correct instrument to assess the population under study. Therefore, an instrument was chosen for this study that was appropriate for assessing depressive symptoms in the general population for college students. It was expected by the author that depressive symptoms would be a negative predictor for life satisfaction. An examination of the relationship between depressive symptoms and life satisfaction for all the total, single, and partnered samples indicated

that depressive symptoms were indeed significantly negatively correlated with life satisfaction for all three samples. Therefore, depressive symptoms were included as a predictor for the models of all three samples for predicting life satisfaction. As expected, depressive symptoms were a significant negative predictor for all three populations, which underlines the significance of "connection" for human well-being.

The Relationship Variables

Myers (2000) has indicated that individuals who are in happy relationships have greater life satisfaction than individuals who are in unhappy relationships or are not in relationships. The work of multiple authors has indicated that romantic partner support and relationship satisfaction are predictive of health-promoting behaviors (Piercy, 1996; Ptacek et al., 1997). Positive relationship qualities, such as commitment, investment, and relationship satisfaction, have also been shown to be strongly and positively related to life satisfaction (Apt, Hurlbert, Pierce, & White, 1996; Hendrick, 1988). Therefore, the relationship variables of relationship satisfaction, commitment, alternative partner, and investment were examined for their relationship to life satisfaction. Consistent with the work of S. Hendrick (1988), relationship satisfaction, commitment, and investment were each positively and significantly correlated with life satisfaction for the partnered and total samples. As expected, relationship satisfaction, commitment, and investment were not significantly correlated with life satisfaction for the single adults, because those participants were asked to report about relationships in their pasts that had already ended.

Therefore, relationship satisfaction, commitment, and investment were used as predictors of life satisfaction for only the total and partnered samples. Investment and relationship satisfaction were significant predictors only of life satisfaction for the

partnered sample. Although commitment did explain some of the variance for life satisfaction, it was not a significant predictor for the partnered sample, perhaps because it is highly correlated with the other two variables. It is possible that relationship satisfaction, commitment, and investment were not significant predictors for the total sample because there were many more single adults in the total adult sample than partnered adults. Alternative partner was not significantly correlated with life satisfaction for any of the three samples, so it was not used as a predictor variable. Alternative partner may not have a significant impact on life satisfaction for college students because of the possibility that there are many possible partners or for other reasons. Alternative partner might be a significant predictor for other populations.

Limitations

As stated at several points throughout the discussion, one major limitation that existed for this study was that the study was conducted on college freshmen, making it difficult to generalize the results to the wider adult population. Also, the sample was primarily Caucasian, which presented another limitation in generalizing the results to populations of other ethnicities. Therefore, a more ethnically and racially diverse sample would have been more desirable. In addition, the use of self-report in this study only provides one perspective, which is that of the participant. Social desirability bias was possible in the study, because of the participants' possible desire to appear socially acceptable to the experimenter.

Conclusions

Despite the limitations of this study, several important implications can be taken from its findings. Based on the results of the study, it appears that romantic relationships

are extremely important in predicting life satisfaction. Also, it appears that it is important to educate single adults about the importance of disclosing personal information to individuals they can trust so they can have a greater buffer against stress. However, single individuals also engage in more physical activity and report wider social support than partnered individuals, suggesting that their coping skills, while positive, may need to include greater reliance on disclosure in their relationships. The findings of this study are also important for future directions in research and practice.

Recommendations for Future Research

Future studies should include a more ethnically diverse population, with a broader age range. It also might be interesting to study individuals' responses to self-report measures and compare their responses to how others perceive the individual's health-promoting behaviors and relationships. Also, it would be interesting to compare married couples to co-habitating couples to determine whether there are differences in self-care practices. This research could also be extended to the veteran population, as many individuals in the Veterans Administration system are experiencing a greater need for mental health services. Finally, the present study is useful clinically for its applications to individuals who need to develop greater coping skills. The results of this study can help clinicians in aiding clients to increase the number of health-promoting behaviors in their lives and target more effective ways for coping and maintaining well-being.

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APPENDIX A

EXTENDED LITERATURE REVIEW

Finding and maintaining romantic relationships are central tasks of life for most people. Relationships provide people with meaning and help them define who they are. Many songs in American pop culture emphasize romantic relationships and the joy received from them. Some songs emphasize the beauty and the joys of having confidences shared with the person that the songwriter finds to be attractive. These songs also often include the beauty of the partner's physical attributes that show the person is physically fit, such as Madonna's song "Physical Attraction", which emphasizes both the partner's physical beauty and confidences shared with the partner. Songwriters also write about relationships and the support they receive from them. For example, the song "The Wind Beneath My Wings" emphasizes the importance of receiving support from a loved one, and how that support has encouraged the person to believe he or she can succeed in life. Some lessons should be taken from these songs from American pop culture, so people can understand what works to make their lives and their relationships satisfying. The current research emphasizes the importance of behavior that is healthy both emotionally and physically, so that people's relationships can be happier and their lives can be more satisfying.

Health-promoting and self-care behaviors have been investigated frequently and described in the empirical literature as aiding in the prevention of psychopathology and improving "quality of life." The terms "health-promoting" and "self-care" behaviors are used synonymously in this extended literature review and include behaviors that are related to positive well-being such as getting adequate sleep, maintaining good nutrition, and engaging in frequent exercise. They also include having healthy social relationships that involve self-disclosure, self-respect, respect for one's partner, as well as romantic

relationship satisfaction. Past research has included the investigation of health-promoting behaviors, self-care behaviors, and close relationships. However, though one or two of the constructs have been explored in conjunction with each other, most of the constructs have been explored independently from the other constructs.

Previous research has often mentioned the importance of social support in close relationships as one factor in dealing with physical or mental illness. This study focuses on the little explored topic of how wellness and well-being are maintained through the support of a close, loving relationship with a romantic partner. The research examined self-care practices that included physical health behaviors, social support, self-disclosure, relationship satisfaction, and respect. Most previous research has focused on psychopathology as it relates to physical health, social support, self-disclosure, relationship satisfaction (or dissatisfaction), and disrespect. The current study, however, focused on wellness and how people engage in self-care.

As Segrin (2005) stated, "the study of personal well-being encompasses physical health, mental health, social adjustment, and relationship satisfaction. All of these could be conceptualized as markers of quality of life" (p. 547), and Segrin also noted, all of these areas should be studied to advance our knowledge of well-being. Well-being is of central interest to the current research.

The first section of the following literature review describes physical health as a health-promoting/self-care behavior. The sections address social support, self-disclosure, relationship satisfaction, and respect (for one's partner and for self) as health-promoting/self-care behaviors. Well-being is also discussed briefly.

Physical Health-Promoting Behaviors

The importance of physical health is constantly emphasized in the world around us, through the media and numerous gym advertisements to entice people to "get in shape." Gyms advertise the idea that people who are healthier appear to be happier in their lives than those who are not. However, one question that has surfaced in the literature concerns why people either engage or do not engage in behavior related to physical health. One model, which has been theorized to explain why people engage in preventive physical health behaviors, is the Health Belief Model (Neumark-Sztainer & Story, 1996). According to the Health Belief Model, there are four factors that affect whether a person engages in a healthy behavior. These include a) the perception or belief that the person is susceptible to a disease, b) the severity of the disease, c) the benefits of engaging in the health practice, and d) the barriers the health-promoting behavior will provide to prevent the person from acquiring the disease, or whether engaging in the behavior provides more benefits than not engaging in the behavior. Also, the model highlights the importance of self-efficacy or the belief that the person has the ability to change his or her behavior. This model has been applied to both the study of nutrition and exercise (Neumark-Sztainer & Story, 1996; Von Ah, Ebert, Ngamvitroj, Park, & Kang, 2004).

One example of the application of the Health Belief Model would be the belief that a person is at risk for heart disease because he or she has close family members who have a history of heart disease. If the person knows that several members of her family have had heart attacks which were life-threatening and believes that healthy eating prevents heart disease, the person is likely to engage in the health-promoting behavior of

healthy eating. This behavior occurs provided the person has the financial ability to buy more expensive, healthier foods. If the person can afford to buy healthier food and does not feel that buying the healthier food will cause a great strain on the budget, then that person will engage in the health-promoting practice of proper nutrition. Neumark-Stainer et al. (1996) also emphasized the importance of socio-environmental factors, such as social support or lack of social support, when it comes to nutrition and exercise. (The importance of social support as it relates to physical and mental health is explained later in this review.)

One benefit from physical health is also linked to mental health. Physical health has been shown to increase people's confidence in themselves. Previous research has shown that women who engage in exercise regularly have more confidence in their sexuality. For instance, Diagiacopo (2001) demonstrated that increased physical activity in obese women with liberal attitudes improved their perceptions of their personal appearance, increased their sexual activity, and increased their relationship satisfaction (see also Gronbech & Bailey, 1997; Nieman, Custer, Butterworth, Utter, & Henson, 2000). Ball, Crawford, and Kenardy (2004) noted that as women's body mass index (BMI) increases, there are significant negative correlations with career aspirations and life satisfaction. Obese and overweight women also report being more dissatisfied with their work, family relationships, partner relationships, and social activities than women of a healthy weight. Weight control appears to be more difficult for married women than for married men, even though married women practice more health-promoting behaviors than married men do (Piercy, 1996). Another study showed that women who are

physically active perform more health-promoting behaviors than physically active men (Dean, 1989).

While previous research has shown the importance of being physically active as it relates to women, there is also previous research indicating that exercise is beneficial for men's health. In men, regular exercise and a healthy diet were positively correlated with increased intimate activity, higher rates of orgasms, and adequate sexual functioning (White, Case, McWhirter, & Mattison, 1990). Besides the benefits of physical activity as they relate to sexuality, men also benefit from physical activity in other ways. Exercise in men is also related to more positive psychological health, which contrasts with the finding for women that states that exercise is positively related to psychological health only when women have healthy eating attitudes. For women with unhealthy eating attitudes, exercise is related to negative psychological health (Thome & Espelage, 2004).

N. Levy (2003) described subjective well-being as persons' ability to subjectively evaluate their life experiences and life satisfaction. Male and female college-aged students' health promoting behaviors as well as positive psychological health are related to emotional well-being, self-perceived health, physical health, and life satisfaction (N. Levy, 2003). Another study found that for adults across the lifespan, physical exercise, physical health, and relaxation are positively related to positive well-being, and these strategies were most frequently reported as self-care strategies (Hansson, Hilleras, & Forsell, 2005). Positive psychological health results from good nutrition and adequate physical activity, because health behaviors appear to serve as both problem-focused and emotion-focused functions in problem-solving (Ingeldew & McDonaugh, 1998).

However, people appear to be less likely to rely on adequate self-care strategies in times of stress.

Health-promoting and self-care behaviors serve as a buffer to protect people during times of stress. Without adequate coping skills, other areas of the person's life suffer. Unfortunately, these coping skills are generally the first strategies that people do not engage in when they are under periods of stress and strain. Seal (1996) demonstrated that psychiatric inpatients are not as self-nurturing in times of stress as the general public, which results in a greater number of hospitalizations for psychiatric patients. In group and individual therapy at psychiatric hospitals, part of the process of helping psychiatric patients to become well involves teaching coping skills, encouraging patients to be able to anticipate when they are not using self-care strategies, and helping patients assess how to overcome barriers that prevent them from using their self-care strategies. Encouraging the use of positive self-care strategies and helping patients to understand how to implement them often prevent relapse to an inpatient hospital.

Other populations that have been noted to not engage in self-care practices as frequently include college students and medical students, particularly when they are in periods of academic stress (Ball & Bax, 2002; N. Levy, 2003). Several studies have highlighted the need for increased education about self-care practices and how to implement them to improve health (Achterberg & Miller, 2004; Neumark-Sztainer & Story, 1996). Medical students and college students report poor sleeping habits, lack of adequate nutrition, and little to no physical activity during times of academic stress (Ball & Bax, 2002; N. Levy, 2003). Some recent research investigated the use of an educational intervention promoting self-care in a group of 1st year medical students (Ball

& Bax, 2002). It was found that after entering medical school, students' health habits declined, with increased alcohol consumption, decreased sleep, decreased exercise, and decreased socialization. Students who were in the control group that did not receive the intervention were found to be more depressed at finals time and to report poorer quality family and friendship relationships than students who did receive the educational intervention. The intervention program also showed that medical students who were in the intervention group improved their sleep and exercise behaviors (Ball & Bax, 2002). In surveying college students, one study demonstrated that academic performance suffers during times of academic stress (Weidner et al., 1996). Students are more likely to engage in maladaptive health behaviors in times of stress, including high levels of drinking and drug use. These behaviors do not promote physical health and are not adequate in promoting social support because the social interaction is not as intimate in nature as social support that is obtained from non-alcohol and non-drug related interactions (Ball & Bax, 2002; Weidner et al., 1996).

Social Support as a Health Promoting Behavior

Social support is defined in many different ways. One author defined social support as "responsiveness to another's needs and more specifically as acts that communicate caring; that validate the other's worth, feelings or actions; or that facilitate adaptive coping with problems through the provision of information, assistance or tangible resources" (Cutrona, 1996, p. 10). According to Cutrona, within all definitions of social support there is the underlying assumption that in order to get basic needs met, people must be able to depend on each other. Cutrona stated that individuals have a way to meet their ongoing interpersonal needs by having social support, and individuals who

have social support are able to have their needs fulfilled when they experience adversity. Cunningham and Barbee (2000) described how evolution made social support necessary in early human origins. They stated that humans developed a need for social support through evolution, because of the long development period humans needed to learn to walk, use language, and use tools. Humans needed each other to nurture their own development and provide protection, and helpfulness was necessary to aid in the survival of the species.

As a result, social support networks, or "a set of people from whom an individual can reasonably expect to receive help in time of need," (Cunningham & Barbee, 2000, p. 275) developed. In the early days of human origins, humans traveled in nomadic bands where persons could be called upon to support each other because they each needed each other for procuring sustenance and safety. In present day times, humans often have to leave their families behind to obtain jobs that are specialized in their career field, and in some sense there has been greater and greater mobility over the course of human history. Gottlieb (1985) theorized that social support networks consist of three levels. At the macro level, social support concerns how involved a person is in formal institutions (e.g., graduate school, church), and informal sources of support such as family and friends. At the mezzo or intermediate level, the quality and density of relationships is examined within a specific social group, such as a person's friendships. For instance, it is best for a person's well-being to have several groups of friends. A person may have church friends, work friends, and friends on the weekends, resulting in multiple support groups (Cunningham et al., 2000). Finally, at the micro level, one can examine the quality of a person's relationship with the individual with whom he or she has the closest

relationship. For example, at the micro level a person's relationship with his or her partner or best friend might be examined (Gottlieb, 1985).

Certain behaviors characterize social support, and Gottlieb (1978) characterized those support behaviors as falling into one of four categories. Those behaviors were grouped into behaviors which aid in sustaining the person's emotions, behaviors which find a solution to a problem, behaviors that have influence on a person indirectly, and behaviors that take action in the environment (Gottlieb, 1978). In later research, a fifth category for social support was added and included behaviors that are critical and undermining (Gottlieb & Wagner, 1991). Cunningham and Barbee (2000; Barbee & Cunningham, 1995) have written extensively about different types of support-seeking behaviors, including both direct and indirect behaviors.

Direct behaviors

Barbee and Cunningham (1995) noted that people can seek support directly through verbally requesting help by discussing a problem in a factual way (e.g., explaining to another family member that they need to borrow money to buy groceries); letting a supportive person know about the issue (e.g., telling another person that they are feeling sad about a divorce they are experiencing); providing details associated with the problem (e.g., letting a person know why and how a problem began); and telling what steps have already been taken concerning the problem (e.g., letting the other person know that they have tried multiple avenues toward solving the problem themselves). Another way to seek direct social support is non-verbally, which includes indicating distress through emotional reactions, or through other behaviors such as frowning and making eye contact.

Indirect behaviors

People also seek social support through indirect verbal behaviors such as generalized complaining about a situation without asking for help or dropping hints that a problem is present. Cunningham and Barbee (2000) stated that persons who hint or complain about a problem in an indirect way behave this way in order to protect themselves, because they do not clearly ask for help. However, the problem with indirect verbal behaviors is that a potential helper may dismiss a problem and not understand the need to help provide solutions.

People also seek social support through indirect nonverbal behaviors, by showing their feelings through behaviors such as heavy sighs, pouting, or fidgeting. Indirect nonverbal behaviors also cause a problem in eliciting social support because potentially supportive people may try to leave the situation or ignore the person's behaviors because they feel uncomfortable. If people continue to use indirect verbal and nonverbal behaviors, they may cause other people to avoid them instead of supporting them, which is the opposite of what the support seeker desires (Cunningham, Barbee, & Druen, 1997, as cited in Cunningham & Barbee, 2000). As Barbee and Cunningham (1995) found, it is best for a person to be direct about how someone can help meet needs more effectively, because direct approaches are more reliable in eliciting help from others.

Response to support-seeking

Barbee and Cunningham (1995) noted that there are several ways that people respond when called upon to offer social support. *Solve* behaviors are helpful to the person requesting help, because the behaviors involve helping the person to find a solution to the problem through providing information and advice giving. For instance, a

person who is looking for employment might ask another person for help in creating a resume, and the helper might aid the help seeker by giving his or her own resume to use as a model.

Solace behaviors help the person by encouraging the person to think positive thoughts and emphasizing the closeness of the relationship. For example, when someone dies in the Southeastern region of the United States, friends and relatives come to a gathering for the family of the deceased the night before the funeral known as "the receiving of friends." During this time, friends try to support the family by telling them good memories they have of the deceased, along with letting the family know they care about them deeply and are sorry for their loss. Friends also emphasize the close moments they had with the deceased in hopes that this will help the family of the deceased feel connected to others around them in their time of loss.

On the other hand, people sometimes do not react positively to another person's requests for help. *Dismiss* behaviors downplay the importance of the problem, and *escape* behaviors challenge the person's sense of the problem by discouraging the expression of the person's negative feelings. An example of a dismiss behavior is telling someone, "Don't worry about that. It's no big deal." This does not aid the help-seeker in feeling supported, because the help-seeker needs empathy. An example of an escape behavior would be when one romantic partner reports being upset about a problem in the relationship with the other person, and the other person responds by slamming the door and leaving.

One person's reaction to another person's request for support can make a huge impact on the support seeker's life, particularly if the person who is requested to help is

someone with whom the support seeker has a close relationship. As stated by Cutrona (1996), "the primary benefit to the recipient of social support is protection against the deterioration of health and well-being that would otherwise be caused by the pressures of recent or ongoing stressful events" (p. 5). Social support has been found to be the most important self-care and health-promoting behavior in maintaining well-being, even more than physical activity, engaging in pleasurable activities, and relaxation (Hansson, Hilleras, & Forcel, 2005). Often when a client enters a psychologist's office for the first time, one of the first questions a client is asked concerns social support. This is an indirect way for the psychologist to assess a person's mental health and the chance of self-harm.

Previous research has placed an emphasis on the stress-buffering effects of social support. Researchers have contrasting ways of conceptualizing social support. Numerous studies support the "buffer hypothesis" (Coker, Smith, Thompson, McKeown, Bethea, & Davis, 2002), which states that individuals are protected from developing mental disorders when they face difficult life circumstances if they have adequate social support. Researchers differ in their focus on social support, with some researchers choosing to study social support prior to the beginning stages of a crisis and throughout the relationship, and other researchers focusing on socially supportive actions following a crisis.

From both dimensions of studying social support, however, there is the prediction that social support has an effect on health and adjustment, most notably during times of crisis (Cutrona, 1996). Social support appears to be more important for individuals who have an external locus of control than for individuals who have an internal locus of

control in facing difficult life events (Dalgard, Bjork, & Tambs, 1995). Social support has been found to "buffer" even the effects of intimate partner violence in abused women, by aiding in preventing adverse effects to mental health (Coker et al., 2002). Abused women who have greater social support perceive themselves as being more mentally and physically healthy than those that do not, reporting less anxiety, depression, post traumatic stress disorder symptoms, and fewer suicide attempts, after controlling for intimate partner violence incidents and experiences (Coker et al., 2002).

Social support has also been shown to be a "buffer" in dealing with difficult instances involving physical health. A study of diabetes patients who were highly functional demonstrated that social support, particularly the providing of encouragement by spouses and family members, was one of the reasons they were able to maintain a physically and emotionally healthy lifestyle (Miller & Davis, 2005).

Social support from romantic partners is particularly important, because for most people in a romantic relationship, their partner is the person with whom they are the closest emotionally. A successful relationship continues to succeed by a pattern of reciprocal support that is established in the beginning of a relationship and continues throughout the close relationship (Cutrona, 1996). One of the major therapeutic approaches that demonstrates the importance of social support is that of Carl Rogers, who emphasized the importance of self-actualization. Self-actualization occurs when a person feels he or she has received unconditional positive regard or unconditional acceptance and that he or she has been understood by a person of significant worth to him or her (Meador & Rogers, 1973).

Support and relationship satisfaction

Extending Rogers' theory further, one theorist stated that social support increases relationship satisfaction, because the social support a person receives from a partner helps to reduce emotional withdrawal and isolation from the partner (Cutrona, 1996). Also, social support is helpful in preventing depression, which causes problems in the romantic relationship. In addition, social support can lessen the escalation of conflict between the partners. It is possible that social support may increase the level of emotional intimacy in the relationship, because both partners are having good experiences (Cutrona, 1996). Cramer (2006) found that social support is more highly correlated with relationship satisfaction than positive conflict behaviors and suggested that when mental health professionals work with couples, it is more important that couples are encouraged to be more supportive to each other than to work on teaching couples how to resolve conflicts in a different way. He suggested that it is probably best to first teach partners to be supportive to each other in their daily interactions with other people and with their spouse generally, rather than to first try to teach partners to be supportive only in conflict situations. When partners are more supportive, their conflict style also tends to be more positive (Cramer, 2006). Often problems in mental health, such as depression, occur because a person does not have adequate social support, and depression is negatively associated with relationship satisfaction (Fincham, Beach, Harold, & Osborne, 1997; Kurdek, 1999).

Support and health

There are three stages in the process of social support that couples experience in trying to cope with adversity. The first stage involves telling the partner about the

problem. The second stage involves an assessment by the partner of whether his or her support is warranted, and whether the partner will give support. The final stage involves actions in which the partner tries to comfort the other person. The partner's actions can have the intended effect of comforting the person. However, the partner's actions can also not be effective at comforting the other person, which can evoke anger or disappointment from the comfort seeker (Pearlin & McCall, 1990, as cited in Cutrona, 1996). Successful negotiation of the process of social support is helpful to both partners, because it aids in helping both partners to maintain health, mentally and physically (Cutrona, 1996).

The finding that support from a romantic partner is most important in health-promoting behaviors has been shown in several studies. One study showed that homosexual men who were HIV positive had fewer depressive and anxiety symptoms when they had supportive partners (Hays, McKusich, Pollack, Hilliard, Hoff, & Coates, 1993). Further research emphasized the importance of a supportive spouse in helping the other partner maintain health behaviors such as nutrition and exercise, even when partners were of normal weight (Neumark-Sztainer et al., 1996).

Social support from spouses can affect recovery from medical problems and aid in promoting physical health, as well. In a study of cardiac rehabilitation patients and their partners, several factors predicted continued compliance with exercise. These factors included high relationship satisfaction for both partners in the relationship, low levels of hostility directed toward the patient by the romantic partner, the partner's positive beliefs about exercise, and the partner's belief that the patient would comply with exercising (Jones, 2002). Social support is also important in maintaining well-being for partners

who are the caregivers of their spouses. Segrin, Badger, Sieger, Meek, and Lopez (2006) found that men who had spouses who were diagnosed with breast cancer had the best mental health if they received social support. Social support was found to be of particular importance in maintaining mental health, the more the man was distressed. Marital satisfaction and spousal support have been found to be even more important than social support from friendships for married people and increase the probability that men and women will engage in more health-promoting behaviors (Piercy, 1996; Ptacek, Pierce, Dodge, & Ptacek, 1997). Social support from family and friends does not appear to compensate for lack of spousal support in married individuals (Coyne & Anderson, 1999; Coyne & DeLongis, 1986; Pistrang & Barker, 1995).

One way that social support can begin is by willingness to self-disclose to a partner about one's own personal experiences. The other partner can also self-disclose to provide support, resulting in a stronger romantic relationship.

Self-Disclosure as a Health-Promoting Behavior

Self-disclosure has been defined as what individuals verbally relate to others about personal information such as the individual's private thoughts, feelings, and experiences (Derlega, Metts, Petronio, & Margulis, 1993). However, in close relationships, there is often a fear of taking the risk of self-disclosure with another person, because rejection may result. For example, one study demonstrated that anxiety concerning self-disclosure is highly correlated with aversiveness in a partner's response to the person self-disclosing. Also, anxiety about self-disclosure has been found to have a negative correlation with high self-esteem for both men and women in marital relationships (Schumm, Figley, & Fuhs, 1981). If a partner holds on to this fear, though,

there is a possibility that adverse effects can occur in the areas of both physical and mental health (Derlega et al., 1993).

Largely, previous work on self-disclosure has explored the topic of disclosing traumatic events to other people, and not specifically in the context of close relationships. Previous research has demonstrated that self-disclosure promotes health in a variety of settings and groups of people, and that inhibition of disclosing traumatic, stressful events has an adverse effect on health. Pennebaker (1990) examined what he described as the "holding back-opening up continuum" (p. 20) and developed what he described as an organizational framework for self-disclosure. According to Pennebaker's (1990) framework, there are several reasons why people need to self-disclose their emotional reactions to traumatic events. Pennebaker (1990) stated that inhibiting emotional events is a physiological process and thus requires physical work to exert control over thoughts, feelings, and behaviors. He also stated that inhibition causes biological changes in people both in the short-term and long-term, and these changes have consequences. In addition, by inhibiting particular thoughts, feelings, and behaviors, people influence their thinking abilities.

Disclosure and health

Through inhibition, the ability to make sense of an emotional event is blocked, because it is rarely translated into language. Therefore the emotional experience must be translated into a person's dreams, ruminations, and maladaptive cognitions. Pennebaker (1990) argued that when people confront trauma psychologically and acknowledge their emotions, they are able to reduce the negative effects of inhibition both psychologically and physiologically so that they reduce their bodies' overall stress level. Finally,

confrontation of trauma helps people to develop greater understanding of an event and finally accept what happened to them, which causes cognitive restructuring to occur (e.g., Lieblich, McAdams, & Josselson, 2004; Pennebaker, 1990). The work of Lutgendorf and Antoni (1999) extended Pennebaker's (1990) work by demonstrating that negative, intrusive thoughts decreased as people self-disclosed about traumatic events. Consistent with Pennebaker's (1990) findings, participants in the Lutgendorf and Antoni (1999) study demonstrated improved immune functioning following self-disclosure about emotional traumas. The participants who self-disclosed had a decreased amount of Epstein-Barr virus antibodies in their bloodstream (Lutgendorf & Antoni, 1999).

Support for Pennebaker's (1990) arguments for acceptance of difficult events, emotions, and traumas is evident in many areas of culture. For example, the hallmark of mental health treatment includes clients disclosing their deepest personal fears and feelings to a mental health care provider. A number of religious faiths such as Judaism, Islam, Catholicism, and Protestantism promote the idea of self-disclosure through prayer to a Higher Power, speaking to a spiritual leader, and sharing with an accountability partner so a person can heal emotionally and spiritually (Pennebaker, 1990). Richards, Beal, Seagal, and Pennebaker (2000) demonstrated that the physical health of maximum security psychiatric inmates, particularly the physical health of sex offenders, was significantly improved following self-disclosure of emotional, traumatic experiences through writing about them.

Research has shown that as emotions and thoughts about traumatic experiences are suppressed, the immune system is less effective (Petrie, Booth, & Pennebaker, 1998). Multiple survey studies of college students and adults have demonstrated that having

traumas in early childhood is associated with a higher likelihood of health problems as an adult and more frequent visits to health care professionals (Pennebaker, 1989). In a study of men who had recently lost their jobs, it was found that men who engaged in written self-disclosure that was related to their feelings and thoughts about their job loss obtained new employment more quickly than those who wrote about other topics or did not write at all (Spera, Buhrfeind, & Pennebaker, 1994). Helgeson (1991) found that post-myocardial infarction patients who had low rates of self-disclosure to their partners were more likely to have difficulty in recovery than patients who did disclose to their partners.

There are several additional reasons why self-disclosure is beneficial to health and why non-disclosure has adverse effects on health. Derlega et al. (1993) give multiple reasons for these effects, including the premise that not disclosing possibly causes feelings of shame and guilt. Without another person to act as a sounding board, those dealing with guilt may begin to define their self-worth through experiences that occurred to them that were not their fault. Also, when persons are able to self-disclose, they have a greater chance of eliciting social support. Wills (1985, 1990, as cited in Derlega et al., 1993) theorized that there are four ways that a person can benefit by confiding in another person, including esteem support, informational support, instrumental support, and motivational support. When a person obtains esteem support, another person can help the person to feel more in control of the situation and have a greater sense of personal value. When a person obtains informational support, the other person in the interaction is helpful, because that person can provide "information, advice, and guidance in coping with a problem" (Derlega et al., 1993, p. 101). Through eliciting instrumental support, a person can benefit by receiving support from the confidant in a more practical way, such

as the other person providing help with going to the grocery store or caring for a person who is sick. Finally, motivational support involves supporting the person eliciting support through providing encouragement in situations when the person feels defeated (Derlega et al., 1993).

Risks of self-disclosure

Although self-disclosure aids in promoting health, there are situations in which self-disclosure is not helpful. Self-disclosure definitely involves a certain amount of risk, so people who are disclosing must take care to consider to whom they are disclosing. If the person to whom the person is self-disclosing is not to be trusted, a lot of pain can result from a broken confidence. Four specific reasons why it is not healthy to disclose should be noted. For instance, in certain situations, it may not be best to self-disclose, because more negative feelings can result from the disclosure. When persons are experiencing heightened self-awareness, self-disclosure can be harmful because they may feel worse about themselves if they are providing information about real or imagined weaknesses. It is possible that persons may feel worse about themselves due to focusing on the difference between their real self and their ideal self (Duval & Wickland, 1972, as cited in Derlega et al., 1993).

In addition, when persons anticipate an upsetting event, talking about their negative feelings may adversely affect their ability to cope, because their negative feelings may increase. When an individual is undergoing stress and other individuals he or she is close to are going through the same or similar experiences, anxiety levels may increase because the sharing of worries can cause the surfacing of more negative thoughts that the person had not previously considered. Finally, when a person intimately self-

discloses to another person who does not provide positive social support, more stress can result, because the other person's negative reaction to the individual can confirm a person's belief of being unworthy or at fault. In addition, persons may be less likely to self-disclose in the future, because they did not receive the support they desired in their previous experience, resulting in health problems. Also, the listener of a person who is self-disclosing may experience feelings of discomfort that result in rejection of the self-disclosing person.

One study suggested that men and women who self-disclose too much personal information report as little satisfaction with their interpersonal relationships, including opposite sex friendships, same sex friendships, and romantic relationships, as those who self-disclose too little personal information (Lombardo & Wood, 1979). Moderate self-disclosers are the most satisfied with their interpersonal relationships. It appears that moderate self-disclosers have a better chance of having good relationships, because they tend to self-disclose at the appropriate level and at the appropriate time. In contrast, a high self-discloser discloses too soon, which possibly results in the hearer thinking that the person is maladjusted and has negative attributes. Therefore, the high self-disclosing person causes rejection from other people, resulting in greater isolation. Low self-disclosers are also avoided by others, because they do not allow others to get to know them, resulting in further isolation and less chance for establishing positive relationships. Also, people tend to find interactions with low self-disclosers to be less rewarding, because low self-disclosers do not reciprocate information about themselves when others provide information about themselves (Lombardo & Wood, 1979).

Disclosure, health, and relationships

Overall, studies have shown that self-disclosure appears to be health-promoting for most individuals, if the previously mentioned negative feedback situations do not occur (Derlega et al., 1993). Several studies have indicated that a lack of self-disclosure generally results in adverse effects. These adverse effects due to inhibition are also present specifically within the context of close relationships, since the effects relate to overall health. Byers (2005) found that poor communication, which includes lack of self-disclosure, is associated with decreases in both relationship satisfaction and sexual satisfaction. In contrast, people with good communication skills with their partners, including higher levels of self-disclosure, are more satisfied with their romantic relationship (Byers, 2005).

Further evidence suggests that self-disclosure affects healing and coping ability, both physical and emotional, after the breakup of a relationship (Lepore & Greenberg, 2002). A study comparing experimental participants to control participants demonstrated this finding. Experimental participants were asked to write about their feelings concerning the breakup of their relationships. By contrast, control participants were asked to write about impersonal topics. Experimental participants did not report any increases in upper respiratory infections, tension, or fatigue. Control participants, on the other hand, experienced increased upper respiratory symptoms in the short-term, along with more tension and fatigue over time. This study also showed that experimental participants were more likely to reunite with an ex-partner than were control participants. The authors of the study stated that the upper respiratory illness experienced by the control group was likely due to the stress of incomplete cognitive processing regarding

the breakup, which therefore caused an increase in the possibility for illness. They also stated that the stress likely caused the suppression of the immune system and this resulted in a greater likelihood of illness (Lepore & Greenberg, 2002). Therefore, it is clear from previous studies that closely related to the construct of self-disclosure is that of well-being, which is also related to an ability to truly be oneself in a relationship. The ability to be one's self in a relationship is also positively related to relationship satisfaction.

Relationship Satisfaction as a Health-Promoting Behavior

As previously mentioned, romantic partner support and relationship satisfaction are both predictive of health-promoting behaviors (Piercy, 1996; Ptacek et al., 1997). Piercy (1996) showed that marital satisfaction is helpful to both men and women in practicing health-promoting behaviors, although it is more helpful to men than women. Relationship satisfaction has been shown to aid in maintaining well-being for men when their partners have been diagnosed with breast cancer (Segrin et al., 2006). Relationship satisfaction also appears to be related to other constructs. For example, relationship satisfaction is particularly important in order for women to experience sexual satisfaction (Byers, 2001; Byers, 2005), and marital satisfaction and sexual satisfaction are also important criteria for women in maintaining a healthy disposition, high life satisfaction, and positive relationship characteristics (Apt, Hurlbert, Pierce, & White, 1996).

In addition, relationship satisfaction is affected by psychopathology for both partners in a relationship. Depression and anxiety both significantly negatively affect people's satisfaction with their own relationship, and a person's depression negatively affects the person's partner's relationship satisfaction (Fincham, Beach, Harold, & Osborne, 1997). Psychopathology such as depression and anxiety may result from a lack

of instituting self-care/health-promoting behaviors. Also, previous research has demonstrated that people generally tend to choose partners who are as psychologically unhealthy or psychologically healthy as they are (Whisman, Uebelacker, & Weinstock, 2004).

Satisfaction and disclosure

Other constructs to which relationship satisfaction is related include communication and sexual satisfaction. McCabe (1999) found that men and women in committed relationships place equal importance on communication and the interpersonal aspects of a relationship, which affects their sexual satisfaction and relationship satisfaction. Two constructs that predict relationship satisfaction in young couples are reciprocity and quality of self-disclosure, and previous research has shown that people are less likely to self-disclose to their partner when they disengage from a romantic relationship (Baxter, 1979; S. Hendrick, 1981; S. Hendrick, 1988; Meeks, S. Hendrick, & Hendrick, 1998; Schumm, Barnes, Bollman, Jurich, & Bugaighis, 1986). S. Hendrick, Hendrick, and Adler (1988) noted that self-disclosure is both intrapersonal (affected by a person's temperament, experiences, etc.) and interpersonal, because it involves one individual relating to another individual. Self-disclosure, like relationship satisfaction, is positively correlated with self-esteem, health-promoting behaviors, and self-care in a number of studies (S. Hendrick et al., 1998; Pennebaker, 1990; Pennebaker & Seagal, 1999; Pennebaker, Kiecolt-Glaser, & Glaser, 1988).

S. Hendrick et al. (1988) demonstrated that for men, self-disclosure to a partner was predictive of own relationship satisfaction, and self-esteem was positively related to partner relationship satisfaction. For women, the perception of being able to elicit self-

disclosure from a partner and self-disclosing to a partner were positively related to their self-esteem. In addition, couples who were more self-disclosing and had higher relationship satisfaction at one point in time were more likely to be together two months later than couples lower in disclosure and satisfaction. The study also demonstrated that perceptions of the level of self-disclosure and love felt for a partner were just as important as the reality of what occurred in the relationship (S. Hendrick et al., 1988). Marital satisfaction is positively related to self-disclosure reciprocity between partners.

Some research (S. Hendrick, 1981) has indicated that both men and women in a marital relationship blame more marriage problems on wives. This blaming may be because women and men in traditional sex roles still tend to hold women responsible for maintaining relationships, a role which also includes eliciting and providing self-disclosure more than men (S. Hendrick, 1981). Although both women and men see self-disclosure as being important in determining relationship quality, disclosure is more highly related to quality for women than for men. Relationship satisfaction has been predicted strongly by intimacy (which includes self-disclosure), agreement, independence, and sexuality for both men and women (Hassebrauck & Fehr, 2002).

Self-disclosure, either verbally or through writing, has been shown to strengthen romantic relationships and increase relationship commitment, as well as to provide healing for physical symptoms and emotional traumas (McKenna, Green, & Gleason, 2002; Pennebaker & Chung, 2007; Slatcher & Pennebaker, 2006). One study showed that disclosure of emotional traumas increases immune function in the blood (Pennebaker et al., 1988). Therefore, it appears that the intimacy of satisfying romantic relationships, which includes quality self-disclosure between both partners, aids in promoting healing

for romantic partners. When times are difficult and stresses surface that challenge emotional and physical health, partners are each other's "soft place to fall."

Another study found that self-disclosure in heterosexual dating relationships predicted the love a person had for their partner (Rubin, Hill, Peplau, & Dunkel-Schetter, 1980). The study investigated the concept that traditional sex roles have dictated that women were more self-disclosing than men. However, when asked about the amount of self-disclosure they engaged in with their partner, men perceived themselves to be engaging in full self-disclosure to their partners on a wide variety of diverse topics. Although men had the perception of being fully self-disclosing, the results of the study indicated that women disclose more to their partners, and that overall women are more self-disclosing than men in several areas, such as their greatest fears. For couples in relationships where women and men had more egalitarian roles, both of the partners were more self-disclosing than in relationships where both partners held more traditional sex roles. The study also indicated that there was a strong positive relationship between love and the amount of self-disclosure couples engaged in (Rubin, Hill, Peplau, & Dunkel-Schetter, 1980).

Online relationships

Self-disclosure appears to promote trust and aids in cementing commitment in multiple types of relationships. For instance, self-disclosure appears to be of particular importance in helping people to express themselves online to form close relationships with others. Online relationships have become an increasingly important way for people to meet each other, as can be seen through numerous chat rooms and websites devoted to aiding in creating friendships and close relationships. One study showed that people who

expressed their emotions through writing about their romantic relationships were more likely to remain committed to their relationship, and that certain word patterns in their instant messages predicted relationship success (Slatcher & Pennebaker, 2006). McKenna et al. (2002) found that people who self-disclosed their "true selves" over the internet were more likely to form close relationships with other people they met online, and then translate those relationships to "face to face" relationships that were still intact two years later.

Self-disclosure also appears to go hand in hand with the construct of respect, because, as noted by Lawrence-Lightfoot (2000), one dimension of respect is the ability to attend fully to a person who shares confidences.

Respect as a Health-Promoting Behavior

The concept of respect

The idea of respect has long been emphasized as being of value in multiple cultures around the world. For instance, when children are small, they are taught to respect their mothers and fathers, as well as other adults who are family members. Previous research on respect has focused on respect as a value within Latino/Latina cultures (Hirsch, 2003). By definition, *respeto* emphasizes the importance of harmony in interpersonal relationships and can be characterized by the avoidance of conflict in the interest of maintaining a quality relationship. Within the context of American pop culture, the song "RESPECT" by Aretha Franklin emphasizes the desire for respect in a close relationship (Lawrence-Lightfoot, 2000).

In the area of psychology, respect has been frequently mentioned in the context of close relationships. However, the importance of specifically studying the concept of

respect has just recently been emphasized in research on close relationships. Some of this research has been inspired by the writings of sociologist Sara Lawrence-Lightfoot (2000), who stressed the importance of respect through documenting the lives of several people who demonstrated different qualities of respect. Lawrence-Lightfoot acknowledged that those who command respect from others also treat others with respect. In her book, she noted one particular example of an African American man who was still treated with respect by Caucasians during the time period of segregation in the United States, because he treated them with respect and also had self-respect.

In Lawrence-Lightfoot's (2000) book, six qualities are noted that characterize respect, including dialogue (being able to engage in genuine communication), attention (being fully engaged), curiosity (having true interest in the thoughts, feelings, and fears of other people), healing (helping others to feel worthy through nurturing), empowerment (aiding others in being independent in their decision-making through helping them to believe in themselves and their abilities), and self-respect (believing in one's own positive qualities).

Research on respect

Although they acknowledged the work of Lawrence-Lightfoot (2000), Frei and Shaver (2002) employed a more clearly empirical approach to systematically explore respect in close relationships. They noted previous researchers have often mentioned the construct of respect as a predictor of success in romantic relationships, but these researchers had not created a way to measure respect or how it relates to close relationships. Through their first study of respect, Frei and Shaver (2002) used a prototype approach to try to operationalize the construct of respect. They found that

respect was not seen as an emotion, but instead as an attitude directed toward a person with whom a respondent was close. They also found that in order to have an attitude of respect toward someone else, the respected person needed to be a person who could be trusted, who thought of the rights and feelings of others, and who was accepting.

In their second study of respect, Frei and Shaver (2002) found that there were 31 dimensions of the construct of respect that were consistent across ethnic groups. In their third study, the scholars developed a scale to measure respect, the 45-item Respect For Partner Scale. Their findings indicated that respect was very strongly positively correlated with relationship satisfaction. Because Frei and Shaver (2002) found that the correlation was such a strong positive one (r = .73) for respect and relationship satisfaction, they questioned whether relationship satisfaction and respect for partner were two separate constructs or possibly two dimensions of a single construct. Certainly, their findings warrant further exploration. In their study, Frei and Shaver (2002) found that respectworthiness of someone else was intertwined in most partnered people's minds with moral integrity, being able to be trusted, being admirable, having honesty, and having concern about the welfare of others.

S. Hendrick and Hendrick (2006) also examined the construct of respect, building conceptually directly on Lawrence-Lightfoot's (2000) work. Their intention was to develop a scale which measured respect toward a person's romantic partner and that could be used both clinically and in close relationship research. Across three studies, they developed the six-item Respect Toward Partner Scale. In their research, the construct of respect toward romantic partner was correlated with both love attitudes and sexual attitudes, as well as with relationship satisfaction and other relational variables.

The scale was also correlated with relationship commitment, self-disclosure, and Frei and Shaver's (2002) Respect For Partner Scale. S. Hendrick and Hendrick (2006), like Frei and Shaver, defined respect as an attitude composed of emotion, cognition, and behavior. Unlike Frei and Shaver, whose scale emphasized a partner's "respectworthiness," the Hendricks oriented their scale toward the respondent's respect for the partner.

They also stated that respect involved equality, or two people being in mutual standing in the relationship, and support, or feeling that a person could trust another person with his or her confidences through providing empathy. When couples are asked about love in the context of romantic relationships, generally respect is one of the first words that surfaces. This result is expected, because it is hard to imagine being in a happy relationship with another person when one or both partners do not respect themselves or each other. Respect is necessary for the success of romantic relationships, because relationships are not quality relationships when there is no respect. However, research on respect is limited, and needs to continue to be developed. The current research had several purposes, one of which was further developing the concept of respect as it relates to other aspects of self-care. It is also important to briefly consider the construct of well-being.

Well-Being

As noted in the beginning of the Introduction, well-being is extremely important and can be considered almost a proxy for general quality of life (e.g., Segrin, 2005). Diener (2000) stated that "subjective well-being in colloquial terms is sometimes labeled 'happiness' " (p. 34). In addition, subjective well-being can be understood as the way that people evaluate how satisfied they are with their lives. According to Diener (2000),

there are a number of different facets of subjective well-being, which include life satisfaction (how happy a person is with life overall), satisfaction with specific areas of a person's life (such as how satisfied a person is with her job or her romantic relationship), positive affect (how many emotions and moods a person experiences in the pleasant realm of emotional functioning), and low levels of unpleasant emotional experiences (little negative affect in a person's emotions and moods). As the focus of this review is on romantic relationships, physical health, and emotional health, well-being will be discussed in these specific areas of a person's life for the purposes of this research. Continuing with the idea of exploring subjective well-being in these domains, it is important to demonstrate how romantic relationships contribute to well-being. Myers (2000) examined romantic relationships and how they relate to well-being. Based on Myers' (2000) findings, research demonstrates that most people are happier when they are in a romantic relationship than when they are not. There is a caveat to these findings, however, because previous research has demonstrated that while married people are happier and have greater life satisfaction than people who are separated or divorced, this is only true if a marriage is a happy one. Myers (2000) also found that the constructs of marriage and happiness have an effect on each other that is bi-directional, meaning that a happy marriage can have an effect on overall happiness and vice versa. Veenhoven (1988) theorized that this double effect occurs because persons who are happier make better marriage partners because they tend to be more extraverted, more attuned to others' needs, and more good-natured, which therefore makes them more attractive to other people. People who are miserable tend to be difficult for others to maintain a relationship with, because they are not as pleasant to be around (Veenhoven, 1988). Therefore,

people who are positive and happy tend to form happier relationships more easily (Myers, 2000).

Also contributing to well-being is emotional health and physical health. Taylor, Kemeny, Reed, Bower, and Gruenewald (2000) reviewed the literature and found multiple studies suggesting that positive emotional health has long been linked to a more meaningful and more physically healthy life. Previous findings have suggested that traumatic and stressful experiences in a person's life do not necessarily have to lead to depression, but can instead lead to positive outcomes depending on how a person approaches coping emotionally with the event (Frankl, 1963; O'Leary & Ickovics, 1995; Schaefer & Moos, 1992). Positive outcomes can result from these events, which can include a person finding a greater sense of personal meaning with life and helping the person to form stronger relationships (Leeham, Meyerowitz, Muirhead, & Frist, 1995).

Depressive Symptoms

As noted previously, strong social support, good physical health, successful romantic relationships, self-disclosure, respect for self and one's partner, and other health promoting behaviors appear to be related to well-being. However, it is important to note that problems in some or all of these areas of a person's life could potentially lead to poor coping skills which can result in depressive symptoms. For this reason, it is important to understand how depression has been assessed by previous researchers. Nezu, Nezu, McClure, and Zwick (2002) note that there are many assessments available for use in determining how to assess depressive symptoms for a particular research design. The authors report that in choosing an assessment instrument for depression the researcher's goals for the assessment, the researcher's target population to be assessed, the value of

the instrument used, and the information source should all be considered. Nezu et al. (2002) also state that for behavioral prediction in clinical research, it is useful to include a measure of depressive symptoms, because the predictive validity of the research enables clinicians to better treat their clients and to be more able to interpret warning signs to protect clients from self harm or from harming others. The authors recommend choosing an assessment that has already been used for the population under study in the researcher's research so that the measure can accurately assess that particular subgroup. The authors state that the reasoning behind using a measure already known to be used with the subgroup the researcher is investigating is because individuals who suffer from depression vary in terms of levels of depression, ranging from mild to severe (Nezu et al., 2002). Nezu et al. (2002) also recommend using an instrument that has been assessed for use across cultures if a researcher is studying the general population so as to avoid double meanings and problems that arise from questions which have different meanings in different cultures. In addition, a cost-benefit analysis for assessing depression is important so that the researcher can determine whether the amount of time required of the participants and the researcher, as well as potential ethical concerns when using a particular assessment, warrant collecting the necessary data (Nezu et al., 2002). Finally, the authors note that both self-report and clinician-rated measures each have their advantages and disadvantages. Self-report measures usually do not require as much of participants' time as do clinician-rated measures, but self-report data are subject to respondent bias. Clinician-rated measures may provide more accurate information, but require more time of the researcher and the respondent, because many measures require additional training of the clinician for administration. When assessing depression, it is

best to use a combination of clinician-rated and self-report measures to address the problems associated with both types of measures (Nezu et al., 2002). However, as stated earlier, a cost-benefit analysis is also useful, and a researcher may choose only one type of measure, while acknowledging the downfalls of the type of measure. The time required of the participant and the researcher may only permit the use of one measure, as other measures assessing other variables might also be necessary for the purposes of the study.

The Current Study

The present study involved the relationships among the health-promoting behaviors of physical health, social support, relationship satisfaction, self-disclosure, respect (i.e., respect for self and respect for partner), well-being, and depression. Health-promoting and self-care behaviors such as relationship satisfaction, social support, physical health, self-disclosure, and respect are important contributors to a person's well-being. Health-promoting behaviors have been studied within the construct of physical health in terms of nutrition and exercise (Hannson et al. 2005; Walker, Sechrist, & Pender, 1987). Health-promoting behaviors have been examined within the construct of social support in terms of social support and romantic relationships and the different kinds of social support others can provide (Cramer, 2006; Walker et al., 1987). Self-disclosure has been explored as a construct that aids in promoting physical health by allowing people to release their feelings about difficult emotional experiences that have happened to them. Self-disclosure has also been shown to predict relationship satisfaction (Meeks et al., 1998). In addition, relationship satisfaction is a health-promoting behavior, as reflected by studies which demonstrate that people who are

involved in a supportive romantic relationship engage in more physically healthy behaviors and recover from problems involving threats to physical health more quickly (Coyne et al., 1999; Jones, 2002). Previous studies have also demonstrated that respect for partner is predictive of relationship satisfaction, indicating that respect is a health-promoting behavior.

Another reason for studying the relationship between physical health, social support, self-disclosure, respect, relationship satisfaction, and well-being is that each of these constructs has been explored only in relationship to one or a few of the other constructs. Such exploration does not account for the possibility that if one construct has a relationship to another construct, and that construct has a relationship to yet another construct, then all three constructs most likely also have an association with each other. For instance, previous research has shown that people perform more physical health-promoting behaviors when they are in a romantic relationship (Piercy, 1996; Ptacek, Pierce, Dodge, & Ptacek, 1997). If this finding is expanded further, there is a possibility that physical health promotes relationship satisfaction. Also, self-disclosure is related to relationship satisfaction (Meeks et al., 1998) and physical health (Pennebaker & Chung, 2007; Pennebaker et al., 1988). Physical health has an association with social support, indicating that people who have strong social support are happier in their lives (Ball, 2002). Finally, respect is an inherent part of relationships, indicating that respect is most likely positively related to social support, because social support and respect both have been shown to predict relationship satisfaction (Frei & Shaver, 2002; S. Hendrick & Hendrick, 2006).

Therefore, the current research explored the associations between each of the health-promoting constructs mentioned previously and the associations between these constructs and overall well-being, which is considered here as a proxy for quality of life.

APPENDIX B

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BIBLIOGRAPHY

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APPENDIX C

NOTE TO PARTICIPANTS

Note to Participants

This research project is concerned with health behavior, attitudes, and beliefs about romantic relationships, and general well-being. Some of the questionnaires are concerned with general attitudes and beliefs and others with more specific relationship beliefs and attitudes.

These questionnaires have been carefully designed. From your scores and those of many other people, we will perform a variety of statistical analyses. From the data provided by you and other people, we will be able to learn how individual characteristics are intertwined with attitudes and beliefs about health behavior and romantic relationships.

Because this research is scientific in nature, it requires large numbers of people in order to draw scientific generalizations. It is not meant to describe particular individuals in any sense. In fact, your responses will remain completely anonymous. Your name will not be associated with your responses in any way. There are no "right" answers; the best answer is the one that is most correct for you.

NOTE: Please make sure that you complete ALL the items. Missed items invalidate the entire questionnaire. However, if you find any part of this questionnaire personally offensive, you do not have to finish it. You may withdraw at any time without penalty.

DO NOT MARK THE QUESTIONNAIRE. PLEASE MARKE YOUR RESPONSES ON THE SCANTRON PROVIDED. **THANK YOU FOR YOUR PARTICIPATION!!**

APPENDIX D

BACKGROUND INVENTORY

PLEASE ANSWER ALL ITEMS CAREFULLY

READ ALL INSTRUCTIONS

BACKGROUND INVENTORY

On the answer sheet, please fill in the response that answers the questions accurately for you.

1. I am a: (A) Male (B) Female

2. My ethnic heritage is:
   (A) Asian or Pacific Islander
   (B) African-American (Black), not of Hispanic origin
   (C) Mexican-American/ Hispanic (D) European-American (Anglo) (E) Other

3. My age is:
   (A) 19 or less (B) 20-22 (C) 23-30 (D) 31-40 (E) 41 or over

4. My family's total income last year was:
   (A) $20,000 or less (B) $21,000 to $40,000 (C) $41,000 to $60,000
   (D) $61,000 to $80,000 (E) $81,000 – up

5. The quality of my parents' marriage is/was (if deceased or divorced):
   (A) Very good (B) Good (C) Average (D) Poor (E) Very poor

6. I have the following number of brothers and sisters:
   (A) None-only child (B) One (C) Two (D) Three
   (D) Four or more

7. I would describe myself as:
   (A) Very outgoing (B) Outgoing (C) Average (D) Quiet
   (E) Very quiet

8. The way I feel about myself generally is:
   (A) Very positive (B) Positive (C) Average (D) Negative
   (E) Very negative

9. I would describe my life right now as:
   (A) Very happy (B) Happy (C) Okay (D) Unhappy
   (E) Very unhappy

The following questions deal with your personal history and current experience with love and romantic relationships. Please answer each question. Select only one answer per item.

10. How many times have you been in love?
(A) None (B) One (C) Two (D) Three to five
(E) More than five

11. Have you ever been in love with more than one person at the same time?
(A) No (B) Yes

12. Are you in love now? If "Yes", how long?
(A) No (B) Yes, one month or less
(C) Yes, one to three months
(D) Yes, three months to one year (E) Yes, over one year

13. Are you currently in a romantic relationship with the person you love? If "Yes,", how long?
(A) No (B) Yes, one month or less (C) Yes, one to three months
(D) Yes, three months to one year (E) Yes, over one year

14. Have you fallen out of love or had a relationship break up in the last few months?
(A) No (B) Yes

15. If you are currently involved in a romantic relationship, is your relationship a sexual relationship?
(A) Not in a relationship (B) No, it is not sexual
(C) Yes, it is a sexual relationship

16. Are you currently in love with someone in addition to or instead of your relationship partner?
(A) Not in a relationship (B) No (C) Yes

17. Do you live with your relationship partner?
(A) Not in a relationship (B) No (C) Yes

18. How many previous romantic relationships have you had?
(A) None (B) One (C) Two (D) Three (E) Four or more

19. How many previous sexual relationships have you been involved in?
(A) None (B) One (C) Two (D) Three (E) Four or more

20. What is your marital status?
(A) Single, never married (B) Married and living with spouse
(C) Married but separated (D) Divorced
(E) Previously divorced and now remarried

21. How much sexual desire do you currently experience for your partner?
(A) Not in a relationship (B) No sexual desire (C) Very little desire
(D) Moderate desire (E) High sexual desire

22. Do you plan to get married or have a long-term partnered relationship?
(A) No (B) Yes (C) Not sure

23. Do you plan to have children?
(A) No (B) Yes (C) Not sure

APPENDIX E

THE SATISFACTION WITH LIFE SCALE

The Satisfaction with Life Scale

Below are five statements with which you may agree or disagree. Using the 1-5 scale below, indicate your agreement with each item by placing the appropriate letter on the scantron form. Please be open and honest in your responding.

A = Strongly Disagree
B = Disagree
C = Neither
D = Agree
E = Strongly Agree

24. In most ways my life is close to my ideal.

25. The conditions of my life are excellent.

26. I am satisfied with my life.

27. So far I have gotten the most important things I want in life.

28. If I could live my life over, I would change almost nothing.

APPENDIX F

RELATIONSHIP ASSESSMENT SCALE

RELATIONSHIP ASSESSMENT SCALE

Please mark on the answer sheet the letter for each item which best answers that item for you.

29. How well does your partner meet your needs?

A	B	C	D	E
Poorly		Average		Extremely well

30. In general, how satisfied are you with your relationship?

A	B	C	D	E
Unsatisfied		Average		Extremely satisfied

31. How good is your relationship compared to most?

A	B	C	D	E
Poor		Average		Excellent

32. How often do you wish you hadn't gotten in this relationship?

A	B	C	D	E
Never		Average		Very often

33. To what extent has your relationship met your original expectations?

A	B	C	D	E
Hardly at all		Average		Completely

34. How much do you love your partner?

A	B	C	D	E
Not much		Average		Very much

35. How many problems are there in your relationship?

A	B	C	D	E
Very few`		Average		Very many

36. Overall, how do you feel about yourself?

A	B	C	D	E
Very poor		Average		Very good

37. How likely is it that your current relationship will be permanent?

A	B	C	D	E
Very unlikely		Uncertain		Very likely

38. How likely is it that you and your current partner will be together six months from now?

A	B	C	D	E
Very unlikely		Uncertain		Very likely

39. In your opinion, how committed is your partner to this relationship?

A	B	C	D	E
Not much		Average		Very committed

40. How committed are you to this relationship?

A	B	C	D	E
Not much		Average		Very committed

41. How good are your chances of attracting another potential partner?

A	B	C	D	E
Poor		Average		Very good

42. How good are your partner's chances of attracting another potential partner?

A	B	C	D	E
Poor		Average		Very good

43. All things considered, how much effort (time, resources, emotion, etc.) have you put into your relationship?

A	B	C	D	E
Not much		Average		Very much

44. All things considered, how much effort (time, resources, emotion, etc.) has your partner put into your relationship?

A	B	C	D	E
Not much		Average		Very much

APPENDIX G

RESPECT SCALE

Respect Scale

Feelings of respect are important for many types of social relationships. We are interested in how respect might be related to romantic relationships. Whenever possible, answer the questions below with your current romantic partner in mind.

For each statement:

A = Strongly agree with the statement
B = Moderately agree with the statement
C = Neutral—neither agree nor disagree
D = Moderately disagree with the statement
E = Strongly disagree with the statement

45. I respect my partner.

46. I am interested in my partner as a person.

47. I am a source of "healing" for my partner.

48. I honor my partner.

49. I approve of the person my partner is.

50. I communicate well with my partner.

51. My partner respects me.

52. My partner is interested in me as a person.

53. My partner is a source of "healing" for me.

54. My partner honors me.

55. My partner approves of the person I am.

56. My partner communicates well with me.

57. I have self-respect.

APPENDIX H

SELF-DISCLOSURE INDEX

Self-Disclosure Index

Listed below are several statements that reflect different approaches to interpersonal communication. For each statement fill in the response on the answer sheet that indicates how much you agree or disagree with that statement as it applies to your own behavior. For each statement:

A=Strongly agree with the statement
B=Moderately agree with the statement
C=Neutral – Neither agree nor disagree
D=Moderately disagree with the statement
E=Strongly disagree with the statement

I HAVE TALKED ABOUT THE FOLLOWING SUBJECTS TO A LOVE PARTNER:

58. My personal habits.

59. Things I have done which I feel guilty about.

60. Things I wouldn't do in public.

61. My deepest feelings.

62. What I like and dislike about myself.

63. What is important to me in life.

64. What makes me the person I am.

65. My worst fears.

66. Things I have done which I am proud of.

67. My close relationships with other people.

APPENDIX I

MULTIDIMENSIONAL SCALE OF PERCEIVED SOCIAL SUPPORT

Multidimensional Scale of Perceived Social Support

A = Strongly Agree
B = Agree
C = Neutral
D = Disagree
E = Strongly Disagree

68. There is a special person who is around when I am in need.

69. There is a special person with whom I can share my joys and sorrows.

70. My family really tries to help me.

71. I get the emotional help and support I need from my family.

72. I have a special person who is a real source of comfort for me.

73. My friends really try to help me.

74. I can count on my friends when things go wrong.

75. I can talk about my problems with my family.

76. I have friends with whom I can share my joys and sorrows.

77. There is a special person in my life who cares about my feelings.

78. My family is willing to help me make decisions.

79. I can talk about my problems with my friends.

APPENDIX J

HEALTH PROMOTING LIFESTYLE PROFILE II

Health Promoting Lifestyle Profile II

Directions: This questionnaire contains statements about your *present* way of life or personal habits. Please respond to each item as accurately as possible, and try not to skip any item. Indicate the frequency with which you engage in each behavior by filling in the response on the answer sheet that indicates how often you engage in the activity as part of your own behavior. For each statement:

Never (N) = A
Sometimes (S) = B
Often (O) = C
Routinely (R) = D

Physical Activity

80. Follow a planned exercise program.

81. Exercise vigorously for 20 or more minutes at least three times a week (such as brisk walking, bicycling, aerobic dancing, using a stair climber).

82. Take part in light to moderate physical activity (such as sustained walking 30-40 minutes 5 or more times a week).

83. Take part in leisure-time (recreational) physical activities (such as swimming, dancing, bicycling).

84. Do stretching exercises at least 3 times per week.

85. Get exercise during usual daily activities (such as walking during lunch, using stairs instead of elevators, parking car away from destination and walking).

86. Check my pulse rate when exercising.

87. Reach my target heart rate when exercising.

Nutrition

88. Choose a diet low in fat, saturated fat, and cholesterol.

89. Limit use of sugars and food containing sugar (sweets).

90. Eat 6-11 servings of bread, cereal, rice, and pasta each day.

91. Eat 2-4 servings of fruit a day.

92. Eat 3-5 servings of vegetables per day.

93. Eat 2-3 servings of milk, yogurt, or cheese each day.

94. Eat only 2-3 servings from the meat, poultry, fish, dried beans, eggs, and nuts group each day.

95. Read labels to identify nutrients, fats, and sodium content in packaged food.

96. Eat breakfast.

APPENDIX K

CENTER FOR EPIDEMIOLOGICAL STUDIES—DEPRESSED MOOD SCALE

Center for Epidemiological Studies—Depressed Mood Scale

Using the scale below, indicate the number which best describes how often you felt or behaved this way—DURING THE PAST WEEK.

1 = Rarely or none of the time (less than 1 day)
2 = Some or a little of the time (1-2 days)
3 = Occasionally or a moderate amount of the time (3-4 days)
4 = Most or all of the time (5-7 days)

DURING THE PAST WEEK:

97. I was bothered by things that usually don't bother me.
98. I did not feel like eating; my appetite was poor.
99. I felt that I could not shake off the blues even with help from my family or friends.
100. I felt that I was just as good as other people.
101. I had trouble keeping my mind on what I was doing.
102. I felt depressed.
103. I felt that everything I did was an effort.
104. I felt hopeful about the future.
105. I thought my life had been a failure.
106. I felt fearful.
107. My sleep was restless.
108. I was happy.
109. I talked less than usual.
110. I felt lonely
111. People were unfriendly.
112. I enjoyed life.
113. I had crying spells.
114. I felt sad.
115. I felt that people disliked me.
116. I could not get "going."

THANK YOU VERY MUCH FOR YOUR PARTICIPATION!

APPENDIX L

DESCRIPTIVE STATISTICS AND ANALYSIS OF VARIANCE FOR FORMAT

Table 12

Descriptive Statistics for Format (Online vs. Paper)

Format	Mean	S.D.	N
Online	3.58	0.64	262
Paper	3.65	0.87	52

Note. $N = 262$ for online format, $N = 52$ for paper format.

Table 13

Analysis of Variance for Format (Online vs. Paper)

Source	*SS*	*df*	*MS*	*F*	*Sig.*
Format	0.21	1	0.21	0.46	0.50
Error	144.30	312	0.46		
Total	144.51	313			

Note. $p < .05$. $N = 262$ online, $N = 52$ paper. The Satisfaction with Life Scale was the outcome variable.